

S2995-3

543.22

ARTICLE 16

543.23

HEALTH CARE AFFORDABILITY AND DELIVERY

543.24

Section 1. [62J.86] DEFINITIONS.

543.25

Subdivision 1. **Definitions.** For the purposes of sections 62J.86 to 62J.92, the following

543.26 terms have the meanings given.

543.27

Subd. 2. **Advisory council.** "Advisory council" means the Health Care Affordability

543.28 Advisory Council established under section 62J.88.

543.29

Subd. 3. **Board.** "Board" means the Health Care Affordability Board established under

543.30 section 62J.87.

544.1

Sec. 2. [62J.87] HEALTH CARE AFFORDABILITY BOARD.

544.2

Subdivision 1. **Membership.** (a) The Health Care Affordability Board consists of 13

544.3 members, appointed as follows:

544.4

(1) five members appointed by the governor;

UES2995-2

52.1

ARTICLE 2

52.2

HEALTH CARE AFFORDABILITY AND DELIVERY

52.4

THE FOLLOWING SECTION HAS BEEN MOVED UP FROM UES2995-2,

52.5 

ARTICLE 2, SECTION 1, SUBDIVISION 1

Subdivision 1. **Definitions.** (a) For purposes of sections 62J.0411 to 62J.0415, the

following terms have the meanings given.

52.6

(b) "Commission" means the Health Care Affordability Commission.

52.7

(c) "Commissioner" means the commissioner of health.

52.8

(d) "Health care entity" includes but is not limited to clinics, hospitals, ambulatory

52.9 surgical centers, physician organizations, accountable care organizations, integrated provider

52.10 and plan systems, county-based purchasing plans, and health plan companies.

52.11

(e) "Health care provider" or "provider" means a health care professional who is licensed

52.12 or registered by the state to perform health care services within the provider's scope of

52.13 practice and in accordance with state law.

52.14

(f) "Health plan" means a health plan as defined in section 62A.011, subdivision 3.

52.15

(g) "Health plan company" means a health carrier as defined under section 62A.011,

52.16 subdivision 2.

52.17

(h) "Hospital" means an entity licensed under sections 144.50 to 144.58.

52.3

Section 1. [62J.0411] HEALTH CARE AFFORDABILITY COMMISSION.

UES2995-2, ARTICLE 2, SECTION 1, SUBDIVISION 1, HAS BEEN MOVED  
UP TO MATCH S2995-3, ARTICLE 16, SECTION 1

52.18

Subd. 2. **Commission membership.** (a) The commissioner of health shall establish a

52.19 health care affordability commission that shall consist of the following 15 members:

52.20

(1) two members with expertise and experience in advocating on behalf of patients;

544.5 (2) two members appointed by the majority leader of the senate;

544.6 (3) two members appointed by the minority leader of the senate;

544.7 (4) two members appointed by the speaker of the house; and

544.8 (5) two members appointed by the minority leader of the house of representatives.

544.9 (b) All appointed members must have knowledge and demonstrated expertise in one or  
544.10 more of the following areas: health care finance, health economics, health care management  
544.11 or administration at a senior level, health care consumer advocacy, representing the health  
544.12 care workforce as a leader in a labor organization, purchasing health care insurance as a  
544.13 health benefits administrator, delivery of primary care, health plan company administration,  
544.14 public or population health, and addressing health disparities and structural inequities.

544.15 (c) A member may not participate in board proceedings involving an organization,  
544.16 activity, or transaction in which the member has either a direct or indirect financial interest,  
544.17 other than as an individual consumer of health services.

544.18 (d) The Legislative Coordinating Commission shall coordinate appointments under this  
544.19 subdivision to ensure that board members are appointed by August 1, 2023, and that board

52.21 (2) two Minnesota residents who are health care consumers, one residing in greater  
52.22 Minnesota and one residing in a metropolitan area, one of whom represents an underserved  
52.23 community;

52.24 (3) one member representing Indian Tribes;

52.25 (4) two members of the business community who purchase health insurance for their  
52.26 employees, one of whom purchases coverage in the small group market;

52.27 (5) two members representing public purchasers of health insurance for their employees;

52.28 (6) one licensed and certified health care provider employed at a federally qualified  
52.29 health center;

52.30 (7) one member representing a health care entity or urban hospitals;

53.1 (8) one member representing rural hospitals;

53.2 (9) one member representing health plans;

53.3 (10) one member who is an expert in health care financing and administration; and

53.4 (11) one member who is an expert in health economics.

53.5 (b) All members appointed must have the knowledge and demonstrated expertise in one  
53.6 of the following areas of expertise, and each area of expertise must be met by at least one  
53.7 member of the commission:

53.8 (1) health care finance, health economics, and health care management or administration  
53.9 at a senior level;

53.10 (2) health care consumer advocacy;

53.11 (3) representing the health care workforce as a leader in a labor organization;

53.12 (4) purchasing health insurance representing business management or health benefits  
53.13 administration;

53.14 (5) delivering primary care, health plan administration, or public or population health;  
53.15 or

53.16 (6) addressing health disparities and structural inequities.

53.17 (c) No member may participate in commission proceedings involving an individual  
53.18 provider, purchaser, or patient or a specific activity or transaction if the member has direct  
53.19 financial interest in the outcome of the commission's proceedings other than as an individual  
53.20 consumer of health care services.

544.20 members as a whole meet all of the criteria related to the knowledge and expertise specified  
544.21 in paragraph (b).

544.22 Subd. 2. **Terms.** (a) Board appointees shall serve four-year terms. A board member shall  
544.23 not serve more than three consecutive terms.

544.24 (b) A board member may resign at any time by giving written notice to the board.

544.25 Subd. 3. **Chair; other officers.** (a) The board shall elect a chair by a majority of the  
544.26 members. The chair shall serve for two years.

544.27 (b) The board shall elect a vice-chair and other officers from its membership as it deems  
544.28 necessary.

544.29 Subd. 4. **Staff; technical assistance; contracting.** (a) The board shall hire a full-time  
544.30 executive director and other staff, who shall serve in the unclassified service. The executive  
545.1 director must have significant knowledge and expertise in health economics and demonstrated  
545.2 experience in health policy.

545.3 (b) The attorney general shall provide legal services to the board.

545.4 (c) The Health Economics Division within the Department of Health shall provide  
545.5 technical assistance to the board in analyzing health care trends and costs and in setting  
545.6 health care spending growth targets.

545.7 (d) The board may employ or contract for professional and technical assistance, including  
545.8 actuarial assistance, as the board deems necessary to perform the board's duties.

53.21 Subd. 3. **Terms.** (a) The commissioners of health, human services, and commerce shall  
53.22 make recommendations for commission membership. Commission members shall be  
53.23 appointed by the governor. The initial appointments to the commission shall be made by  
53.24 September 1, 2023. The initial appointed commission members shall serve staggered terms  
53.25 of three or four years determined by lot by the secretary of state. Following the initial  
53.26 appointments, the commission members shall serve four-year terms. Members may not  
53.27 serve more than two consecutive terms.

53.28 (b) The commission is governed by section 15.0575, except as otherwise provided in  
53.29 this section.

53.30 (c) A commission member may resign at any time by giving written notice to the  
53.31 commission.

54.1 Subd. 4. **Chair; other officers.** (a) The governor shall annually designate a member to  
54.2 serve as chair of the commission. The chair shall serve for one year. If there is a vacancy  
54.3 for any cause, the governor shall make an appointment for that category of membership and  
54.4 expertise, to become immediately effective.

54.5 (b) The commission shall elect a vice-chair and other officers from its membership as  
54.6 it deems necessary.

THE FOLLOWING SUBDIVISION WAS MOVED UP FROM UES2995-2,  
ARTICLE 2, SECTION 1, SUBDIVISION 8

54.24 Subd. 8. **Staff; technical assistance; contracting.** (a) The commission shall hire a  
54.25 full-time executive director and administrative staff who shall serve in the unclassified  
54.26 service. The executive director must have significant knowledge and expertise in health  
54.27 economics and demonstrated experience in health policy.

54.28 (b) The attorney general shall provide legal services to the commission.

54.29 (c) The commissioner of health shall provide technical assistance to the commission  
54.30 related to collecting data, analyzing health care trends and costs, and setting health care  
54.31 spending growth targets.

THE FOLLOWING SUBDIVISION WAS MOVED UP FROM UES2995-2,  
ARTICLE 2, SECTION 1, SUBDIVISION 11

545.9 Subd. 5. **Access to information.** (a) The board may request that a state agency provide  
545.10 the board with any publicly available information in a usable format as requested by the  
545.11 board, at no cost to the board.

545.12 (b) The board may request from a state agency unique or custom data sets, and the agency  
545.13 may charge the board for providing the data at the same rate the agency would charge any  
545.14 other public or private entity.

545.15 (c) Any information provided to the board by a state agency must be de-identified. For  
545.16 purposes of this subdivision, "de-identification" means the process used to prevent the  
545.17 identity of a person or business from being connected with the information and ensuring  
545.18 all identifiable information has been removed.

545.19 (d) Any data submitted to the board shall retain its original classification under the  
545.20 Minnesota Data Practices Act in chapter 13.

545.21 Subd. 6. **Compensation.** Board members shall not receive compensation but may receive  
545.22 reimbursement for expenses as authorized under section 15.059, subdivision 3.

545.23 Subd. 7. **Meetings.** (a) Meetings of the board are subject to chapter 13D. The board shall  
545.24 meet publicly at least quarterly. The board may meet in closed session when reviewing  
545.25 proprietary information as specified in section 62J.71, subdivision 4.

545.26 (b) The board shall announce each public meeting at least two weeks prior to the  
545.27 scheduled date of the meeting. Any materials for the meeting shall be made public at least  
545.28 one week prior to the scheduled date of the meeting.

545.29 (c) At each public meeting, the board shall provide the opportunity for comments from  
545.30 the public, including the opportunity for written comments to be submitted to the board  
545.31 prior to a decision by the board.

55.24 Subd. 11. **Access to information.** (a) The commission or commissioner may request  
55.25 that a state agency provide the commission with data as defined in sections 62J.04 and  
55.26 295.52 in a usable format as requested by the commission, at no cost to the commission.

55.27 (b) The commission may request from a state agency unique or custom data sets, and  
55.28 the agency may charge the commission for providing the data at the same rate the agency  
55.29 would charge any other public or private entity. The commission may grant the commissioner  
55.30 access to this data.

55.31 (c) Any information provided to the commission or commissioner by a state agency  
55.32 must be de-identified. For purposes of this subdivision, "de-identified" means the process  
56.1 used to prevent the identity of a person from being connected with information and ensuring  
56.2 all identifiable information has been removed.

56.3 (d) Any data submitted to the commission or the commissioner shall retain their original  
56.4 classification under the Minnesota Data Practices Act in chapter 13.

56.5 (e) The commissioner, under the authority of chapter 62J, may collect data necessary  
56.6 for the performance of its duties, and shall collect this data in a form and manner that ensures  
56.7 the collection of high-quality, transparent data.

54.7 Subd. 5. **Compensation.** Commission members may be compensated according to  
54.8 section 15.0575.

54.9 Subd. 6. **Meetings.** (a) Meetings of the commission, including any public hearings, are  
54.10 subject to chapter 13D.

54.11 (b) The commission must meet publicly on at least a monthly basis until the initial growth  
54.12 targets are established.

54.13 (c) After the initial growth targets are established, the commission shall meet at least  
54.14 quarterly to consider summary data presented by the commissioner, draft report findings,  
54.15 consider updates to the health care spending growth target program and growth target levels,  
54.16 discuss findings with health care providers and payers, and identify additional analyses and  
54.17 strategies to limit health care spending growth.

UES2995-2, ARTICLE 2, SECTION 1, SUBDIVISION 7, WAS MOVED DOWN  
TO MATCH S2995-3, ARTICLE 16, SECTION 5, SUBDIVISION 5

UES2995-2, ARTICLE 2, SECTION 1, SUBDIVISION 8, WAS MOVED UP TO  
MATCH S2995-3, ARTICLE 16, SECTION 2, SUBDIVISION 4

55.1 Subd. 9. **Administration.** The commissioner of health shall provide office space,  
55.2 equipment and supplies, and analytic staff support to the commission and the Health Care  
55.3 Affordability Advisory Council.

546.1       Sec. 3. **[62J.88] HEALTH CARE AFFORDABILITY ADVISORY COUNCIL.**

546.2           Subdivision 1. **Establishment.** The governor shall appoint a Health Care Affordability  
546.3 Advisory Council to provide advice to the board on health care costs and access issues and  
546.4 to represent the views of patients and other stakeholders. Members of the advisory council  
546.5 shall be appointed based on their knowledge and demonstrated expertise in one or more of  
546.6 the following areas: health care delivery, ensuring health care access for diverse populations,  
546.7 public and population health, patient perspectives, health care cost trends and drivers, clinical  
546.8 and health services research, innovation in health care delivery, and health care benefits  
546.9 management.

55.4           Subd. 10. **Duties of the commissioner.** (a) The commissioner, in consultation with the  
55.5 commissioners of commerce and human services, shall provide staff support to the  
55.6 commission, including performing and procuring consulting and analytic services. The  
55.7 commissioner shall:  
  
55.8           (1) establish the form and manner of data reporting, including reporting methods and  
55.9 dates, consistent with program design and timelines formalized by the commission;  
  
55.10          (2) under the authority in chapter 62J, collect data identified by the commission for use  
55.11 in the program in a form and manner that ensures the collection of high-quality, transparent  
55.12 data;  
  
55.13          (3) provide analytical support, including by conducting background research or  
55.14 environmental scans, evaluating the suitability of available data, performing needed analysis  
55.15 and data modeling, calculating performance under the spending trends, and researching  
55.16 drivers of spending growth trends;  
  
55.17          (4) assist health care entities subject to the targets with reporting of data, internal analysis  
55.18 of spending growth trends, and, as necessary, methodological issues;  
  
55.19          (5) synthesize information and report to the commission; and  
  
55.20          (6) make appointments and staff the Health Care Affordability Advisory Council under  
55.21 section 62J.0414.  
  
55.22          (b) In carrying out the duties required by this section, the commissioner may contract  
55.23 with entities with expertise in health economic, health finance, and actuarial science.

THE FOLLOWING SECTION WAS MOVED UP FROM UES2995-2, ARTICLE 2, SECTION 4

60.29       Sec. 4. **[62J.0414] HEALTH CARE AFFORDABILITY ADVISORY COUNCIL.**

60.30           Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions  
60.31 have the meanings given.  
  
60.32           (b) "Council" means the Health Care Affordability Advisory Council.  
  
61.1           (c) "Commission" means the Health Care Affordability Commission.  
  
61.2           Subd. 2. **Establishment; administration.** (a) The commissioner of health shall appoint  
61.3 a 15-member advisory council to provide technical assistance to the commission. Members  
61.4 shall be appointed based on their knowledge and demonstrated expertise in one or more of  
61.5 the following areas:  
  
61.6           (1) health care spending trends and drivers;  
  
61.7           (2) equitable access to health care services;

546.10 Subd. 2. **Duties; reports.** (a) The council shall provide technical recommendations to  
546.11 the board on:

546.12 (1) the identification of economic indicators and other metrics related to the development  
546.13 and setting of health care spending growth targets;

546.14 (2) data sources for measuring health care spending; and

546.15 (3) measurement of the impact of health care spending growth targets on diverse  
546.16 communities and populations, including but not limited to those communities and populations  
546.17 adversely affected by health disparities.

546.18 (b) The council shall report technical recommendations and a summary of its activities  
546.19 to the board and the chairs and ranking minority members of the legislative committees  
546.20 with primary jurisdiction over health care policy and finance at least annually, and shall  
546.21 submit additional reports on its activities and recommendations to the board, as requested  
546.22 by the board or at the discretion of the council.

61.8 (3) health insurance operation and finance;

61.9 (4) actuarial science;

61.10 (5) the practice of medicine;

61.11 (6) patient perspectives;

61.12 (7) clinical and health services research; and

61.13 (8) the health care marketplace.

61.14 (b) The commissioner shall provide administrative and staff support to the advisory  
61.15 council.

THE FOLLOWING SUBDIVISION WAS MOVED UP FROM UES2995-2,  
ARTICLE 2, SECTION 4, SUBDIVISION 6

62.9 Subd. 6. **Duties.** The council shall:

62.10 (1) provide technical advice to the commission on the development and implementation  
62.11 of the health care spending growth targets, drivers of health care spending, and other items  
62.12 related to the commission duties;

62.13 (2) provide technical input on data sources for measuring health care spending; and

62.14 (3) advise the commission on methods to measure the impact of health care spending  
62.15 growth targets on:

62.16 (i) communities most impacted by health disparities;

62.17 (ii) the providers who primarily serve communities most impacted by health disparities;

62.18 (iii) individuals with disabilities;

62.19 (iv) individuals with health coverage through medical assistance or MinnesotaCare;

62.20 (v) individuals who reside in rural areas; and

62.21 (vi) individuals with rare diseases.

546.23 Subd. 3. **Terms.** (a) Advisory council members shall serve four-year terms.

546.24 (b) Removal and vacancies of advisory council members shall be governed by section  
546.25 15.059.

546.26 Subd. 4. **Compensation.** Advisory council members may be compensated according to  
546.27 section 15.059.

546.28 Subd. 5. **Meetings.** The advisory council shall meet at least quarterly. Meetings of the  
546.29 advisory council are subject to chapter 13D.

546.30 Subd. 6. **Expiration.** Notwithstanding section 15.059, the advisory council shall not  
546.31 expire.

- 61.16 Subd. 3. **Membership.** The council's membership shall consist of:  
61.17 (1) three members representing patients and health care consumers, at least one of whom  
61.18 must have experience working with communities most impacted by health disparities and  
61.19 one of whom must have experience working with persons in the disability community;  
61.20 (2) the commissioner of health or a designee;  
61.21 (3) the commissioner of human services or a designee;  
61.22 (4) one member who is a health services researcher at the University of Minnesota;  
61.23 (5) two members who represent nonprofit group purchasers;  
61.24 (6) one member who represents for-profit group purchasers;  
61.25 (7) two members who represent health care entities;  
61.26 (8) one member who represents independent health care providers;  
61.27 (9) two members who represent employee benefit plans, with one representing a public  
61.28 employer; and  
61.29 (10) one member who represents the Rare Disease Advisory Council.

- 62.1 Subd. 4. **Terms.** (a) The initial appointments to the council shall be made by September  
62.2 30, 2023. The council members shall serve staggered terms of three or four years determined  
62.3 by lot by the secretary of state. Following the initial appointments, the council members  
62.4 shall serve four-year terms. Members may not serve more than two consecutive terms.  
62.5 (b) Removal and vacancies of council members are governed by section 15.059.

- 62.6 Subd. 5. **Meetings.** The council must meet publicly on at least a monthly basis until the  
62.7 initial growth targets are established. After the initial growth targets are established, the  
62.8 council shall meet at least quarterly.

UES2995-2, ARTICLE 2, SECTION 4, SUBDIVISION 6, WAS MOVED UP TO  
MATCH S2995-3, ARTICLE 16, SECTION 3, SUBDIVISION 2

- 62.22 Subd. 7. **Expiration.** Notwithstanding section 15.059, subdivision 6, the council does  
62.23 not expire.



547.1      Sec. 4. **[62J.89] DUTIES OF THE BOARD.**

547.2          Subdivision 1. **General.** (a) The **board** shall monitor the administration and reform of  
547.3 the health care delivery and payment systems in the state. The **board** shall:

547.4          (1) set health care spending growth targets for the state, as specified under section 62J.90;

547.5          (2) enhance the transparency of provider organizations;

547.6          (3) monitor the adoption and effectiveness of alternative payment methodologies;

547.7          (4) foster innovative health care delivery and payment models that lower health care  
547.8 cost growth while improving the quality of patient care;

547.9          (5) monitor and review the impact of changes within the health care marketplace; and

547.10        (6) monitor patient access to necessary health care services.

547.11        (b) The **board** shall establish goals to reduce health care disparities in racial and ethnic  
547.12 communities and to ensure access to quality care for persons with disabilities or with chronic  
547.13 or complex health conditions.

547.14        Subd. 2. **Market trends.** The **board** shall monitor efforts to reform the health care  
547.15 delivery and payment system in Minnesota to understand emerging trends in the commercial  
547.16 health insurance market, including large self-insured employers and the state's public health  
547.17 care programs, in order to identify opportunities for state action to achieve:

547.18        (1) improved patient experience of care, including quality and satisfaction;

547.19        (2) improved health of all populations, including a reduction in health disparities; and

547.20        (3) a reduction in the growth of health care costs.

547.21        Subd. 3. **Recommendations for reform.** The **board** shall make recommendations for  
547.22 legislative policy, market, or any other reforms to:

547.23        (1) lower the rate of growth in commercial health care costs and public health care  
547.24 program spending in the state;

547.25        (2) positively impact the state's rankings in the areas listed in this subdivision and  
547.26 subdivision 2; and

547.27        (3) improve the quality and value of care for all Minnesotans, and for specific populations  
547.28 adversely affected by health inequities.

547.29        Subd. 4. **Office of Patient Protection.** The board shall establish an Office of Patient  
547.30 Protection, to be operational by January 1, 2025. The office shall assist consumers with  
548.1 issues related to access and quality of health care, and advise the legislature on ways to

56.8      Sec. 2. **[62J.0412] DUTIES OF THE COMMISSION; GENERAL.**

56.9          Subdivision 1. **Health care delivery and payment.** (a) The **commission** shall monitor  
56.10 the administration and reform of the health care delivery and payment systems in the state.  
56.11 The **commission** shall:

56.12        (1) set health care spending growth targets for the state;

56.13        (2) enhance the transparency of provider organizations;

56.14        (3) monitor the adoption and effectiveness of alternative payment methodologies;

56.15        (4) foster innovative health care delivery and payment models that lower health care  
56.16 cost growth while improving the quality of patient care;

56.17        (5) monitor and review the impact of changes within the health care marketplace; and

56.18        (6) monitor patient access to necessary health care services.

56.19        (b) The **commission** shall establish goals to reduce health care disparities in racial and  
56.20 ethnic communities and to ensure access to quality care for persons with disabilities or with  
56.21 chronic or complex health conditions.

56.22        Subd. 2. **Duties of the commission; market trends.** The **commission** shall monitor  
56.23 efforts to reform the health care delivery and payment system in Minnesota to understand  
56.24 emerging trends in the commercial health insurance market, including large self-insured  
56.25 employers and the state's public health care programs, in order to identify opportunities for  
56.26 state action to achieve:

56.27        (1) improved patient experience of care, including quality, access to care, and satisfaction;

56.28        (2) improved health of all populations, including a reduction in health disparities; and

56.29        (3) a reduction in the growth of health care costs.

57.1        Subd. 3. **Duties of the commission; recommendations for reform.** The **commission**  
57.2 shall make periodic recommendations for legislative policy, market, or any other reforms  
57.3 to:

57.4        (1) lower the rate of growth in commercial health care costs and public health care  
57.5 program spending in the state;

57.6        (2) positively impact the state's rankings in the areas listed in this subdivision and  
57.7 subdivision 2; and

57.8        (3) improve the quality and value of care for all Minnesotans, and for specific populations  
57.9 adversely affected by health disparities.



548.2 reduce consumer health care spending and improve consumer experiences by reducing  
548.3 complexity for consumers.

548.4       Sec. 5. **[62J.90] HEALTH CARE SPENDING GROWTH TARGETS.**

548.5           Subdivision 1. **Establishment and administration.** The board shall establish and  
548.6 administer the health care spending growth target program to limit health care spending  
548.7 growth in the state, and shall report regularly to the legislature and the public on progress  
548.8 toward these targets.

548.9           Subd. 2. **Methodology.** (a) The board shall develop a methodology to establish annual  
548.10 health care spending growth targets and the economic indicators to be used in establishing  
548.11 the initial and subsequent target levels.

548.12       **(b) The health care spending growth target must:**

548.13       **(1) use a clear and operational definition of total state health care spending;**

548.14       **(2) promote a predictable and sustainable rate of growth for total health care spending**  
548.15 as measured by an established economic indicator, such as the rate of increase of the state's  
548.16 economy or of the personal income of residents of this state, or a combination;

548.17       **(3) define the health care markets and the entities to which the targets apply;**

548.18       **(4) take** into consideration the **potential** for variability in targets across public and private  
548.19 payers;

548.20       **(5) account for the health status of patients; and**

548.21       **(6) incorporate specific benchmarks related to health equity.**

57.10       Sec. 3. **[62J.0413] DUTIES OF THE COMMISSION; GROWTH TARGETS.**

57.11           Subdivision 1. **Growth target program.** The commission is responsible for the  
57.12 development, establishment, and operation of the health care spending growth target program,  
57.13 determining the health care entities subject to health care spending growth targets, and  
57.14 reporting on progress toward targets to the legislature and the public.

57.15           Subd. 2. **Methodologies for growth targets.** (a) The commission shall develop and  
57.16 maintain the health care spending growth target program, and report to the legislature and  
57.17 the public on progress toward achieving growth targets. The commission shall conduct all  
57.18 activities necessary for the successful implementation of the program, in order to limit health  
57.19 care spending growth. The commission shall:

57.20           **(1) establish a statement of purpose;**

57.21           **(2) develop a methodology to establish health care spending growth targets and the**  
57.22 economic indicators to be used in establishing the initial and subsequent target levels;

57.23           **(3) establish health care spending growth targets that:**

57.24           **(i) use a clear and operational definition of total state health care spending;**

57.25           **(ii) promote a predictable and sustainable rate of growth for total health care spending,**  
57.26 as measured by an established economic indicator, such as the rate of increase in the state  
57.27 economy, the personal income of state residents, or a combination;

THE FOLLOWING PARAGRAPH WAS MOVED UP FROM UES2295-2,  
ARTICLE 2, SECTION 3, SUBDIVISION 2, PARAGRAPH (B)

58.9           **(b) The commission, when developing this methodology, shall determine which health**  
58.10 care entities are subject to targets, and at what level of aggregation.

THE FOLLOWING ITEM WAS MOVED UP FROM UES2995-2, ARTICLE 2,  
SECTION 3, PARAGRAPH (A), CLAUSE (4), ITEM (II)

58.5           **(ii) takes** into consideration the **need** for variability in targets across public and private  
58.6 payers;

57.28           **(iii) apply to all health care providers and all health plan companies in the state's health**  
57.29 care system; and

548.22 (c) In developing, implementing, and evaluating the growth target program, the board  
548.23 shall:

548.24 (1) consider the incorporation of quality of care and primary care spending goals;

548.25 (2) ensure that the program does not place a disproportionate burden on communities  
548.26 most impacted by health disparities, the providers who primarily serve communities most  
548.27 impacted by health disparities, or individuals who reside in rural areas or have high health  
548.28 care needs;

548.29 (3) explicitly consider payment models that help ensure financial sustainability of rural  
548.30 health care delivery systems and the ability to provide population health;

549.1 (4) allow setting growth targets that encourage an individual health care entity to serve  
549.2 populations with greater health care risks by incorporating:

549.3 (i) a risk factor adjustment reflecting the health status of the entity's patient mix; and

549.4 (ii) an equity adjustment accounting for the social determinants of health and other  
549.5 factors related to health equity for the entity's patient mix;

549.6 (5) ensure that growth targets:

549.7 (i) do not constrain the Minnesota health care workforce, including the need to provide  
549.8 competitive wages and benefits;

57.30 (iv) are measurable on a per capita basis, statewide basis, health plan basis, and health  
57.31 care provider basis; and

58.1 (4) establish a methodology for calculating health care cost growth that:

58.2 (i) allows measurement statewide and for each health care provider and health plan  
58.3 company, and at the discretion of the commission allows accounting for variability by age  
58.4 and sex;

UES2995-2, ARTICLE 2, SECTION 3, SUBDIVISION 2, CLAUSE (4), ITEM (II), WAS MOVED UP TO MATCH WITH S2995-3, ARTICLE 16, SECTION 5, SUBDIVISION 2, PARAGRAPH (B), CLAUSE (4)

58.7 (iii) incorporates health equity considerations; and

58.8 (iv) considers the impact of targets on health care access and disparities.

THE FOLLOWING PARAGRAPH WAS MOVED UP FROM UES2995-2, ARTICLE 2, SECTION 3, SUBDIVISION 6, PARAGRAPH (A)

59.3 Subd. 6. Additional criteria for growth targets. (a) In developing the health care  
59.4 spending growth target program, the commission may:

59.5 (1) evaluate and ensure that the program does not place a disproportionate burden on  
59.6 communities most impacted by health disparities, the providers who primarily serve  
59.7 communities most impacted by health disparities, or individuals who reside in rural areas  
59.8 or have high health care needs;

59.9 (2) consider payment models that help ensure financial sustainability of rural health care  
59.10 delivery systems and the ability to provide population health;

59.11 (3) consider the addition of quality of care performance measures or minimum primary  
59.12 care spending goals;

59.13 (4) allow setting growth targets that encourage an individual health care entity to serve  
59.14 populations with greater health care risks by incorporating:

59.15 (i) a risk factor adjustment reflecting the health status of the entity's patient mix; and

59.16 (ii) an equity adjustment accounting for the social determinants of health and other  
59.17 factors related to health equity for the entity's patient mix;

59.18 (5) ensure that growth targets:

59.19 (i) encourage the growth of the Minnesota health care workforce, including the need to  
59.20 provide competitive wages and benefits;

549.9 (ii) do not limit the use of collective bargaining or place a floor or ceiling on health care  
549.10 workforce compensation; and  
549.11 (iii) promote workforce stability and maintain high-quality health care jobs; and  
549.12 (6) consult with the advisory council and other stakeholders.

549.13 Subd. 3. **Data.** The board shall identify data to be used for tracking performance in  
549.14 meeting the growth target and identify methods of data collection necessary for efficient  
549.15 implementation by the board. In identifying data and methods, the board shall:  
549.16 (1) consider the availability, timeliness, quality, and usefulness of existing data, including  
549.17 the data collected under section 62U.04;  
549.18 (2) assess the need for additional investments in data collection, data validation, or data  
549.19 analysis capacity to support the board in performing its duties; and  
549.20 (3) minimize the reporting burden to the extent possible.

549.21 Subd. 4. **Setting growth targets; related duties.** (a) The board, by June 15, 2024, and  
549.22 by June 15 of each succeeding calendar year through June 15, 2028, shall establish annual  
549.23 health care spending growth targets for the next calendar year consistent with the  
549.24 requirements of this section. The board shall set annual health care spending growth targets  
549.25 for the five-year period from January 1, 2025, through December 31, 2029.  
549.26 (b) The board shall periodically review all components of the health care spending  
549.27 growth target program methodology, economic indicators, and other factors. The board may  
549.28 revise the annual spending growth targets after a public hearing, as appropriate. If the board  
549.29 revises a spending growth target, the board must provide public notice at least 60 days  
549.30 before the start of the calendar year to which the revised growth target will apply.

59.21 (ii) do not limit the use of collective bargaining or place a floor or ceiling on health care  
59.22 workforce compensation; and  
59.23 (iii) promote workforce stability and maintain high-quality health care jobs; and  
59.24 (6) consult with stakeholders representing patients, health care providers, payers of  
59.25 health care services, and others.

UES2995-2, ARTICLE 2, SECTION 3, SUBDIVISION 2, PARAGRAPH (B),  
WAS MOVED UP TO MATCH S2995-3, SECTION 5, SUBDIVISION 2,  
PARAGRAPH (B), CLAUSE (3)

58.11 Subd. 3. **Data on performance.** The commission shall identify the data to be used for  
58.12 tracking performance toward achieving health care spending growth targets, and adopt  
58.13 methods of data collection. In identifying data and methods, the commission shall:  
58.14 (1) consider the availability, timeliness, quality, and usefulness of existing data;  
58.15 (2) assess the need for additional investments in data collection, data validation, or  
58.16 analysis capacity to support efficient collection and aggregation of data to support the  
58.17 commission's activities;  
58.18 (3) limit the reporting burden to the greatest extent possible; and  
58.19 (4) identify and define the health care entities that are required to report to the  
58.20 commissioner.

58.21 Subd. 4. **Reporting requirements.** The commission shall establish requirements for  
58.22 health care providers and health plan companies to report data and other information  
58.23 necessary to calculate health care cost growth. Health care providers and health plans must  
58.24 report data in the form and manner established by the commission.

58.25 Subd. 5. **Establishment of growth targets.** (a) The commission, by June 15, 2024, shall  
58.26 establish annual health care spending growth targets consistent with the methodology in  
58.27 subdivision 2 for each of the next five calendar years, with the goal of limiting health care  
58.28 spending growth. The commission may continue to establish annual health care spending  
58.29 growth targets for subsequent years.

58.30 (b) The commission shall regularly review all components of the program methodology,  
58.31 including economic indicators and other factors, and, as appropriate, revise established  
59.1 health care spending growth target levels. Any changes to health care spending growth  
59.2 target levels require a two-thirds majority vote of the commission.

THE FOLLOWING PARAGRAPH WAS MOVED UP FROM UES2995-2,  
ARTICLE 2, SECTION 3, SUBDIVISION 6, PARAGRAPH (B)

550.1 (c) The board, based on an analysis of drivers of health care spending and evidence from  
550.2 public testimony, shall evaluate strategies and new policies, including the establishment of  
550.3 accountability mechanisms, that are able to contribute to meeting growth targets and limiting  
550.4 health care spending growth without increasing disparities in access to health care.

550.5 Subd. 5. **Hearings.** At least annually, the board shall hold public hearings to present  
550.6 findings from spending growth target monitoring. The board shall also regularly hold public  
550.7 hearings to take testimony from stakeholders on health care spending growth, setting and  
550.8 revising health care spending growth targets, the impact of spending growth and growth  
550.9 targets on health care access and quality, and as needed to perform the duties assigned under  
550.10 section 62J.89, subdivisions 1, 2, and 3.

550.11 Sec. 6. **[62J.91] NOTICE TO HEALTH CARE ENTITIES.**

550.12 Subdivision 1. **Notice.** (a) The board shall provide notice to all health care entities that  
550.13 have been identified by the board as exceeding the spending growth target for any given  
550.14 year.

550.15 (b) For purposes of this section, "health care entity" shall be defined by the board during  
550.16 the development of the health care spending growth methodology. When developing this  
550.17 methodology, the board shall consider a definition of health care entity that includes clinics,  
550.18 hospitals, ambulatory surgical centers, physician organizations, accountable care  
550.19 organizations, integrated provider and plan systems, and other entities defined by the board,  
550.20 provided that physician organizations with a patient panel of 15,000 or fewer, or which  
550.21 represent providers who collectively receive less than \$25,000,000 in annual net patient  
550.22 service revenue from health plan companies and other payers, shall be exempt.

550.23 Subd. 2. **Performance improvement plans.** (a) The board shall establish and implement  
550.24 procedures to assist health care entities to improve efficiency and reduce cost growth by  
550.25 requiring some or all health care entities provided notice under subdivision 1 to file and

59.26 (b) Based on an analysis of drivers of health care spending by the commissioner and  
59.27 evidence from public testimony, the commission shall explore strategies, new policies, and  
59.28 future legislative proposals that can contribute to achieving health care spending growth  
59.29 targets or limiting health care spending growth without increasing disparities in access to  
59.30 health care, including the establishment of accountability mechanisms for health care entities.

THE FOLLOWING SECTION WAS MOVED DOWN FROM UES2995-2,  
ARTICLE 1, SECTION 1, SUBDIVISION 7

54.18 Subd. 7. **Hearings.** At least annually, the commission shall hold public hearings to  
54.19 present findings from spending growth target monitoring. The commission shall also regularly  
54.20 hold public hearings to take testimony from stakeholders on health care spending growth,  
54.21 setting and revising health care spending growth targets, and the impact of spending growth  
54.22 and growth targets on health care access and quality and as needed to perform assigned  
54.23 duties.

UES2995-2, ARTICLE 2, SECTION 3, SUBDIVISION 6, PARAGRAPH (A),  
WAS MOVED UP TO MATCH S2995-3, ARTICLE 16, SECTION 5,  
SUBDIVISION 2, PARAGRAPH (C)

UES2995-2, ARTICLE 2, SECTION 3, SUBDIVISION 6, PARAGRAPH (B),  
WAS MOVED UP TO MATCH S2995-3, ARTICLE 16, SECTION 5,  
SUBDIVISION 4, PARAGRAPH (C)

UES2995-2, ARTICLE 2, SECTION 3, SUBDIVISION 7, WAS MOVED DOWN  
TO MATCH S2995-3, ARTICLE 16, SECTION 7, SUBDIVISION 1

62.24 Sec. 5. **[62J.0415] NOTICE TO HEALTH CARE ENTITIES.**

62.25 Subdivision 1. **Notice.** The commission shall provide notice to all health care entities  
62.26 that have been identified by the commission as exceeding the health care spending growth  
62.27 target for a specified period as determined by the commission.

62.28 Subd. 2. **Performance improvement plans.** (a) The commission shall establish and  
62.29 implement procedures to assist health care entities to improve efficiency and reduce cost  
62.30 growth by requiring some or all health care entities provided notice under subdivision 1 to  
63.1 file and implement a performance improvement plan. The commission shall provide written

550.26 implement a performance improvement plan. The board shall provide written notice of this  
 550.27 requirement to health care entities.

550.28 (b) Within 45 days of receiving a notice of the requirement to file a performance  
 550.29 improvement plan, a health care entity shall:

550.30 (1) file a performance improvement plan with the board; or

550.31 (2) file an application with the board to waive the requirement to file a performance  
 550.32 improvement plan or extend the timeline for filing a performance improvement plan.

551.1 (c) The health care entity may file any documentation or supporting evidence with the  
 551.2 board to support the health care entity's application to waive or extend the timeline to file  
 551.3 a performance improvement plan. The board shall require the health care entity to submit  
 551.4 any other relevant information it deems necessary in considering the waiver or extension  
 551.5 application, provided that this information shall be made public at the discretion of the  
 551.6 board. The board may waive or delay the requirement for a health care entity to file a  
 551.7 performance improvement plan in response to a waiver or extension request in light of all  
 551.8 information received from the health care entity, based on a consideration of the following  
 551.9 factors:

551.10 (1) the costs, price, and utilization trends of the health care entity over time, and any  
 551.11 demonstrated improvement in reducing per capita medical expenses adjusted by health  
 551.12 status;

551.13 (2) any ongoing strategies or investments that the health care entity is implementing to  
 551.14 improve future long-term efficiency and reduce cost growth;

551.15 (3) whether the factors that led to increased costs for the health care entity can reasonably  
 551.16 be considered to be unanticipated and outside of the control of the entity. These factors may  
 551.17 include but shall not be limited to age and other health status adjusted factors and other cost  
 551.18 inputs such as pharmaceutical expenses and medical device expenses;

551.19 (4) the overall financial condition of the health care entity; and

551.20 (5) any other factors the board considers relevant. If the board declines to waive or  
 551.21 extend the requirement for the health care entity to file a performance improvement plan,  
 551.22 the board shall provide written notice to the health care entity that its application for a waiver  
 551.23 or extension was denied and the health care entity shall file a performance improvement  
 551.24 plan.

551.25 (d) A health care entity shall file a performance improvement plan with the board;

551.26 (1) within 45 days of receipt of an initial notice;

63.2 notice of this requirement to health care entities and describe the form and manner in which  
 63.3 these plans must be prepared and submitted.

63.4 (b) Within 45 days of receiving a notice of the requirement to file a performance  
 63.5 improvement plan, a health care entity shall:

63.6 (1) file a performance improvement plan as specified in paragraph (d); or

63.7 (2) file a request for a waiver or extension as specified in paragraph (c).

63.8 (c) The health care entity may file any documentation or supporting evidence with the  
 63.9 commission to support the health care entity's application to waive or extend the timeline  
 63.10 to file a performance improvement plan. The commission shall require the health care entity  
 63.11 to submit any other relevant information it deems necessary in considering the waiver or  
 63.12 extension application, provided that this information shall be made public at the discretion  
 63.13 of the commission. The commission may waive or delay the requirement for a health care  
 63.14 entity to file a performance improvement plan in response to a waiver or extension request  
 63.15 in light of all information received from the health care entity, based on a consideration of  
 63.16 the following factors:

63.17 (1) the costs, price, and utilization trends of the health care entity over time, and any  
 63.18 demonstrated improvement in reducing per capita medical expenses adjusted by health  
 63.19 status;

63.20 (2) any ongoing strategies or investments that the health care entity is implementing to  
 63.21 improve future long-term efficiency and reduce cost growth;

63.22 (3) whether the factors that led to increased costs for the health care entity can reasonably  
 63.23 be considered to be unanticipated and outside of the control of the entity. These factors may  
 63.24 include but shall not be limited to age and other health status adjusted factors of the patients  
 63.25 served by the health care entity and other cost inputs such as pharmaceutical expenses and  
 63.26 medical device expenses;

63.27 (4) the overall financial condition of the health care entity; and

63.28 (5) any other factors the commission considers relevant.

63.29 If the commission declines to waive or extend the requirement for the health care entity to  
 63.30 file a performance improvement plan, the commission shall provide written notice to the  
 63.31 health care entity that its application for a waiver or extension was denied and the health  
 63.32 care entity shall file a performance improvement plan.

551.27 (2) if the health care entity has requested a waiver or extension, within 45 days of receipt  
551.28 of a notice that such waiver or extension has been denied; or

551.29 (3) if the health care entity is granted an extension, on the date given on the extension.

551.30 The performance improvement plan shall identify the causes of the entity's cost growth and  
551.31 shall include but not be limited to specific strategies, adjustments, and action steps the entity  
551.32 proposes to implement to improve cost performance. The proposed performance improvement  
551.33 plan shall include specific identifiable and measurable expected outcomes and a timetable  
552.1 for implementation. The timetable for a performance improvement plan must not exceed  
552.2 18 months.

552.3 (e) The board shall approve any performance improvement plan that it determines is  
552.4 reasonably likely to address the underlying cause of the entity's cost growth and has a  
552.5 reasonable expectation for successful implementation. If the board determines that the  
552.6 performance improvement plan is unacceptable or incomplete, the board may provide  
552.7 consultation on the criteria that have not been met and may allow an additional time period  
552.8 of up to 30 calendar days for resubmission. Upon approval of the proposed performance  
552.9 improvement plan, the board shall notify the health care entity to begin immediate  
552.10 implementation of the performance improvement plan. Public notice shall be provided by  
552.11 the board on its website, identifying that the health care entity is implementing a performance  
552.12 improvement plan. All health care entities implementing an approved performance  
552.13 improvement plan shall be subject to additional reporting requirements and compliance  
552.14 monitoring, as determined by the board. The board shall provide assistance to the health  
552.15 care entity in the successful implementation of the performance improvement plan.

552.16 (f) All health care entities shall in good faith work to implement the performance  
552.17 improvement plan. At any point during the implementation of the performance improvement  
552.18 plan, the health care entity may file amendments to the performance improvement plan,  
552.19 subject to approval of the board. At the conclusion of the timetable established in the  
552.20 performance improvement plan, the health care entity shall report to the board regarding  
552.21 the outcome of the performance improvement plan. If the board determines the performance  
552.22 improvement plan was not implemented successfully, the board shall:

552.23 (1) extend the implementation timetable of the existing performance improvement plan;

552.24 (2) approve amendments to the performance improvement plan as proposed by the health  
552.25 care entity;

552.26 (3) require the health care entity to submit a new performance improvement plan; or

64.1 (d) The performance improvement plan shall identify the causes of the entity's cost  
64.2 growth and shall include but not be limited to specific strategies, adjustments, and action  
64.3 steps the entity proposes to implement to improve cost performance. The proposed  
64.4 performance improvement plan shall include specific identifiable and measurable expected  
64.5 outcomes and a timetable for implementation. The commission may request additional  
64.6 information as needed, in order to approve a proposed performance improvement plan. The  
64.7 timetable for a performance improvement plan must not exceed 18 months.

64.8 (e) The commission shall approve any performance improvement plan that it determines  
64.9 is reasonably likely to address the underlying cause of the entity's cost growth and has a  
64.10 reasonable expectation for successful implementation. If the commission determines that  
64.11 the performance improvement plan is unacceptable or incomplete, the commission may  
64.12 provide consultation on the criteria that have not been met and may allow an additional time  
64.13 period of up to 30 calendar days for resubmission. Upon approval of the proposed  
64.14 performance improvement plan, the commission shall notify the health care entity to begin  
64.15 immediate implementation of the performance improvement plan. Public notice shall be  
64.16 provided by the commission on its website, identifying that the health care entity is  
64.17 implementing a performance improvement plan. All health care entities implementing an  
64.18 approved performance improvement plan shall be subject to additional reporting requirements  
64.19 and compliance monitoring, as determined by the commission. The commission may request  
64.20 the commissioner to assist in the review of performance improvement plans. The commission  
64.21 shall provide assistance to the health care entity in the successful implementation of the  
64.22 performance improvement plan.

64.23 (f) All health care entities shall in good faith work to implement the performance  
64.24 improvement plan. At any point during the implementation of the performance improvement  
64.25 plan, the health care entity may file amendments to the performance improvement plan,  
64.26 subject to approval of the commission. At the conclusion of the timetable established in the  
64.27 performance improvement plan, the health care entity shall report to the commission  
64.28 regarding the outcome of the performance improvement plan. If the commission determines  
64.29 the performance improvement plan was not implemented successfully, the commission  
64.30 shall:

64.31 (1) extend the implementation timetable of the existing performance improvement plan;

64.32 (2) approve amendments to the performance improvement plan as proposed by the health  
64.33 care entity;

64.34 (3) require the health care entity to submit a new performance improvement plan; or



552.27 (4) waive or delay the requirement to file any additional performance improvement  
552.28 plans.

552.29 Upon the successful completion of the performance improvement plan, the board shall  
552.30 remove the identity of the health care entity from the board's website. The board may assist  
552.31 health care entities with implementing the performance improvement plans or otherwise  
552.32 ensure compliance with this subdivision.

552.33 (g) If the board determines that a health care entity has:

553.1 (1) willfully neglected to file a performance improvement plan with the board within  
553.2 45 days as required;

553.3 (2) failed to file an acceptable performance improvement plan in good faith with the  
553.4 board;

553.5 (3) failed to implement the performance improvement plan in good faith; or

553.6 (4) knowingly failed to provide information required by this subdivision to the board or  
553.7 knowingly provided false information, the board may assess a civil penalty to the health  
553.8 care entity of not more than \$500,000. The board may only impose a civil penalty if the  
553.9 board determines that the health care entity is unlikely to voluntarily comply with all  
553.10 applicable provisions of this subdivision.

553.11 Sec. 7. [62J.92] REPORTING REQUIREMENTS.

553.12 Subdivision 1. **General requirement.** (a) The board shall present the reports required  
553.13 by this section to the chairs and ranking members of the legislative committees with primary  
553.14 jurisdiction over health care finance and policy. The board shall also make these reports  
553.15 available to the public on the board's website.

553.16 (b) The board may contract with a third-party vendor for technical assistance in preparing  
553.17 the reports.

553.18 Subd. 2. **Progress reports.** The board shall submit written progress updates about the  
553.19 development and implementation of the health care spending growth target program by  
553.20 February 15, 2025, and February 15, 2026. The updates must include reporting on board  
553.21 membership and activities, program design decisions, planned timelines for implementation  
553.22 of the program, and the progress of implementation. The reports must include the  
553.23 methodological details underlying program design decisions.

65.1 (4) waive or delay the requirement to file any additional performance improvement  
65.2 plans.

65.3 Upon the successful completion of the performance improvement plan, the commission  
65.4 shall remove the identity of the health care entity from the commission's website.

65.5 (g) If the commission determines that a health care entity has:

65.6 (1) willfully neglected to file a performance improvement plan with the commission  
65.7 within 45 days or as required;

65.8 (2) failed to file an acceptable performance improvement plan in good faith with the  
65.9 commission;

65.10 (3) failed to implement the performance improvement plan in good faith; or

65.11 (4) knowingly failed to provide information required by this subdivision to the  
65.12 commission or knowingly provided false information, the commission may assess a civil  
65.13 penalty to the health care entity of not more than \$500,000. The commission shall only  
65.14 impose a civil penalty as a last resort.

THE FOLLOWING SUBDIVISION WAS MOVED DOWN FROM UES2995-2,  
ARTICLE 2, SECTION 3, SUBDIVISION 7.

60.1 Subd. 7. **Reports.** (a) The commission shall submit the reports specified in this section  
60.2 to the chairs and ranking minority members of the legislative committees with primary  
60.3 jurisdiction over health care. These reports must be made available to the public.



553.24 Subd. 3. Health care spending trends. By December 15, 2025, and every December  
553.25 15 thereafter, the board shall submit a report on health care spending trends and the health  
553.26 care spending growth target program that includes:

553.27 (1) spending growth in aggregate and for entities subject to health care spending growth  
553.28 targets relative to established target levels;

553.29 (2) findings from analyses of drivers of health care spending growth;

553.30 (3) estimates of the impact of health care spending growth on Minnesota residents,  
553.31 including for communities most impacted by health disparities, related to their access to  
553.32 insurance and care, value of health care, and the ability to pursue other spending priorities;

554.1 (4) the potential and observed impact of the health care growth targets on the financial  
554.2 viability of the rural delivery system;

554.3 (5) changes under consideration for revising the methodology to monitor or set growth  
554.4 targets;

554.5 (6) recommendations for initiatives to assist health care entities in meeting health care  
554.6 spending growth targets, including broader and more transparent adoption of value-based  
554.7 payment arrangements; and

554.8 (7) the number of health care entities whose spending growth exceeded growth targets,  
554.9 information on performance improvement plans and the extent to which the plans were  
554.10 completed, and any civil penalties imposed on health care entities related to noncompliance  
554.11 with performance improvement plans and related requirements.

60.4 (b) The commission shall submit written progress updates about the development and  
60.5 implementation of the health care growth target program by February 15, 2024, and February  
60.6 15, 2025. The updates must include reporting on commission membership and activities,  
60.7 program design decisions, planned timelines for implementation of the program, progress  
60.8 of implementation, and comprehensive methodological details underlying program design  
60.9 decisions.

60.10 (c) The commission shall submit by March 31, 2026, and by March 31 annually thereafter,  
60.11 reports on health care spending trends related to the health care growth targets. The  
60.12 commission may delegate preparation of the reports to the commissioner and any contractors  
60.13 the commissioner determines are necessary. The reports must include:

60.14 (1) aggregate spending growth for entities subject to health care growth targets relative  
60.15 to established target levels;

60.16 (2) findings from the analyses of cost drivers of health care spending growth;

60.17 (3) estimates of the impact of health care spending growth on Minnesota residents,  
60.18 including for those communities most impacted by health disparities, including an analysis  
60.19 of Minnesota residents' access to insurance and care, the value of health care, and the state's  
60.20 ability to pursue other spending priorities;

60.21 (4) the potential and observed impact of the health care growth targets on the financial  
60.22 viability of the rural health care delivery system;

60.23 (5) changes in the health care spending growth methodology under consideration;

60.24 (6) recommended policy changes that may affect health care spending growth trends,  
60.25 including broader and more transparent adoption of value-based payment arrangements;  
60.26 and

60.27 (7) an overview of health care entities subject to health care growth targets that have  
60.28 implemented or completed a performance improvement plan.

65.15 Sec. 6. **[62J.0416] IDENTIFY STRATEGIES FOR REDUCTION OF**  
65.16 **ADMINISTRATIVE SPENDING AND LOW-VALUE CARE.**

65.17 (a) The commissioner of health shall develop recommendations for strategies to reduce  
65.18 the volume and growth of administrative spending by health care organizations and group  
65.19 purchasers, and the magnitude of low-value care delivered to Minnesota residents. The  
65.20 commissioner shall:

65.21 (1) review the availability of data and identify gaps in the data infrastructure to estimate  
65.22 aggregated and disaggregated administrative spending and low-value care;

554.12 Sec. 8. Minnesota Statutes 2022, section 62K.15, is amended to read:

554.13 **62K.15 ANNUAL OPEN ENROLLMENT PERIODS; SPECIAL ENROLLMENT**

554.14 **PERIODS.**

554.15 (a) Health carriers offering individual health plans must limit annual enrollment in the

554.16 individual market to the annual open enrollment periods for MNsure. Nothing in this section

554.17 limits the application of special or limited open enrollment periods as defined under the

554.18 Affordable Care Act.

554.19 (b) Health carriers offering individual health plans must inform all applicants at the time

554.20 of application and enrollees at least annually of the open and special enrollment periods as

554.21 defined under the Affordable Care Act.

554.22 (c) Health carriers offering individual health plans must provide a special enrollment

554.23 period for enrollment in the individual market by employees of a small employer that offers

554.24 a qualified small employer health reimbursement arrangement in accordance with United

554.25 States Code, title 26, section 9831(d). The special enrollment period shall be available only

65.23 (2) based on available data, estimate the volume and change over time of administrative

65.24 spending and low-value care in Minnesota;

65.25 (3) conduct an environmental scan and key informant interviews with experts in health

65.26 care finance, health economics, health care management or administration, and the

65.27 administration of health insurance benefits to determine drivers of spending growth for

65.28 spending on administrative services or the provision of low-value care; and

65.29 (4) convene a clinical learning community and an employer task force to review the

65.30 evidence from clauses (1) to (3) and develop a set of actionable strategies to address

65.31 administrative spending volume and growth and the magnitude of the volume of low-value

65.32 care.

66.1 (b) By March 31, 2025, the commissioner shall deliver the recommendations to the

66.2 chairs and ranking minority members of house and senate committees with jurisdiction over

66.3 health and human services finance and policy.

66.4 Sec. 7. **[62J.0417] PAYMENT MECHANISMS IN RURAL HEALTH CARE.**

66.5 (a) The commissioner shall develop a plan to assess readiness of rural communities and

66.6 rural health care providers to adopt value based, global budgeting or alternative payment

66.7 systems and recommend steps needed to implement them. The commissioner may use the

66.8 development of case studies and modeling of alternate payment systems to demonstrate

66.9 value-based payment systems that ensure a baseline level of essential community or regional

66.10 health services and address population health needs.

66.11 (b) The commissioner shall develop recommendations for pilot projects with the aim of

66.12 ensuring financial viability of rural health care entities in the context of spending growth

66.13 targets. The commissioner shall share findings with the health care affordability commission.

554.26 to employees newly hired by a small employer offering a qualified small employer health  
554.27 reimbursement arrangement, and to employees employed by the small employer at the time  
554.28 the small employer initially offers a qualified small employer health reimbursement  
554.29 arrangement. For employees newly hired by the small employer, the special enrollment  
554.30 period shall last for 30 days after the employee's first day of employment. For employees  
554.31 employed by the small employer at the time the small employer initially offers a qualified  
554.32 small employer health reimbursement arrangement, the special enrollment period shall last  
554.33 for 30 days after the date the arrangement is initially offered to employees.

555.1 (d) The commissioner of commerce shall enforce this section.

555.2 (e) Health carriers offering individual health plans through MNsure must provide a  
555.3 special enrollment period as required under the easy enrollment health insurance outreach  
555.4 program under section 62V.13.

555.5 **EFFECTIVE DATE.** This section is effective for taxable years beginning after December  
555.6 31, 2023, and applies to health plans offered, issued, or sold on or after January 1, 2024.

555.7 Sec. 9. Minnesota Statutes 2022, section 62U.04, subdivision 11, is amended to read:

555.8 Subd. 11. **Restricted uses of the all-payer claims data.** (a) Notwithstanding subdivision  
555.9 4, paragraph (b), and subdivision 5, paragraph (b), the commissioner or the commissioner's  
555.10 designee shall only use the data submitted under subdivisions 4 and 5 for the following  
555.11 purposes:

555.12 (1) to evaluate the performance of the health care home program as authorized under  
555.13 section 62U.03, subdivision 7;

555.14 (2) to study, in collaboration with the reducing avoidable readmissions effectively  
555.15 (RARE) campaign, hospital readmission trends and rates;

555.16 (3) to analyze variations in health care costs, quality, utilization, and illness burden based  
555.17 on geographical areas or populations;

555.18 (4) to evaluate the state innovation model (SIM) testing grant received by the Departments  
555.19 of Health and Human Services, including the analysis of health care cost, quality, and  
555.20 utilization baseline and trend information for targeted populations and communities; ~~and~~

555.21 (5) to compile one or more public use files of summary data or tables that must:

555.22 (i) be available to the public for no or minimal cost by March 1, 2016, and available by  
555.23 web-based electronic data download by June 30, 2019;

555.24 (ii) not identify individual patients, payers, or providers;

555.25 (iii) be updated by the commissioner, at least annually, with the most current data  
555.26 available;

66.14 Sec. 8. Minnesota Statutes 2022, section 62U.04, subdivision 11, is amended to read:

66.15 Subd. 11. **Restricted uses of the all-payer claims data.** (a) Notwithstanding subdivision  
66.16 4, paragraph (b), and subdivision 5, paragraph (b), the commissioner or the commissioner's  
66.17 designee shall only use the data submitted under subdivisions 4 and 5 for the following  
66.18 purposes:

66.19 (1) to evaluate the performance of the health care home program as authorized under  
66.20 section 62U.03, subdivision 7;

66.21 (2) to study, in collaboration with the reducing avoidable readmissions effectively  
66.22 (RARE) campaign, hospital readmission trends and rates;

66.23 (3) to analyze variations in health care costs, quality, utilization, and illness burden based  
66.24 on geographical areas or populations;

66.25 (4) to evaluate the state innovation model (SIM) testing grant received by the Departments  
66.26 of Health and Human Services, including the analysis of health care cost, quality, and  
66.27 utilization baseline and trend information for targeted populations and communities; ~~and~~

66.28 (5) to compile one or more public use files of summary data or tables that must:

66.29 (i) be available to the public for no or minimal cost by March 1, 2016, and available by  
66.30 web-based electronic data download by June 30, 2019;

66.31 (ii) not identify individual patients, payers, or providers;

67.1 (iii) be updated by the commissioner, at least annually, with the most current data  
67.2 available;

555.27 (iv) contain clear and conspicuous explanations of the characteristics of the data, such  
555.28 as the dates of the data contained in the files, the absence of costs of care for uninsured  
555.29 patients or nonresidents, and other disclaimers that provide appropriate context; and

555.30 (v) not lead to the collection of additional data elements beyond what is authorized under  
555.31 this section as of June 30, 2015; and

556.1 (6) to provide technical assistance to the Health Care Affordability Board to implement  
556.2 sections 62J.86 to 62J.92.

556.3 (b) The commissioner may publish the results of the authorized uses identified in  
556.4 paragraph (a) so long as the data released publicly do not contain information or descriptions  
556.5 in which the identity of individual hospitals, clinics, or other providers may be discerned.

556.6 (c) Nothing in this subdivision shall be construed to prohibit the commissioner from  
556.7 using the data collected under subdivision 4 to complete the state-based risk adjustment  
556.8 system assessment due to the legislature on October 1, 2015.

556.9 (d) The commissioner or the commissioner's designee may use the data submitted under  
556.10 subdivisions 4 and 5 for the purpose described in paragraph (a), clause (3), until July 1,  
556.11 2023.

556.12 (e) The commissioner shall consult with the all-payer claims database work group  
556.13 established under subdivision 12 regarding the technical considerations necessary to create  
556.14 the public use files of summary data described in paragraph (a), clause (5).

556.15 Sec. 10. **[62V.12] STATE-FUNDED COST-SHARING REDUCTIONS.**

556.16 Subdivision 1. **Establishment.** (a) The board must develop and administer a state-funded  
556.17 cost-sharing reduction program for eligible persons who enroll in a silver level qualified  
556.18 health plan through MNsure. The board must implement the cost-sharing reduction program  
556.19 for plan years beginning on or after January 1, 2024.

556.20 (b) For purposes of this section, an "eligible person" is an individual who meets the  
556.21 eligibility criteria to receive a cost-sharing reduction under Code of Federal Regulations,  
556.22 title 45, section 155.305(g).

67.3 (iv) contain clear and conspicuous explanations of the characteristics of the data, such  
67.4 as the dates of the data contained in the files, the absence of costs of care for uninsured  
67.5 patients or nonresidents, and other disclaimers that provide appropriate context; and

67.6 (v) not lead to the collection of additional data elements beyond what is authorized under  
67.7 this section as of June 30, 2015; and

67.8 (6) to provide technical assistance to the Health Care Affordability Commission to  
67.9 implement sections 62J.0411 to 62J.0415.

67.10 (b) The commissioner may publish the results of the authorized uses identified in  
67.11 paragraph (a) so long as the data released publicly do not contain information or descriptions  
67.12 in which the identity of individual hospitals, clinics, or other providers may be discerned.

67.13 (c) Nothing in this subdivision shall be construed to prohibit the commissioner from  
67.14 using the data collected under subdivision 4 to complete the state-based risk adjustment  
67.15 system assessment due to the legislature on October 1, 2015.

67.16 (d) The commissioner or the commissioner's designee may use the data submitted under  
67.17 subdivisions 4 and 5 for the purpose described in paragraph (a), clause (3), until July 1,  
67.18 2023.

67.19 (e) The commissioner shall consult with the all-payer claims database work group  
67.20 established under subdivision 12 regarding the technical considerations necessary to create  
67.21 the public use files of summary data described in paragraph (a), clause (5).

67.22 Sec. 9. Minnesota Statutes 2022, section 62V.05, is amended by adding a subdivision to  
67.23 read:

67.24 Subd. 13. **Transitional cost-sharing reductions.** (a) The board shall develop and  
67.25 implement, for the 2025 and 2026 plan years only, a system to support eligible individuals  
67.26 who choose to enroll in gold level health plans through MNsure.

67.27 (b) For purposes of this section, an "eligible individual" is an individual who:

67.28 (1) is a resident of Minnesota;

67.29 (2) has a household income that does not exceed 400 percent of the federal poverty  
67.30 guidelines; and

67.31 (3) is enrolled in a gold level health plan offered in the enrollee's county of residence.

68.1 (c) Under the system established in this subdivision, the monthly transitional cost-sharing  
68.2 reduction subsidy for an eligible individual is \$75.

556.23 Subd. 2. **Reduction in cost-sharing.** (a) The cost-sharing reduction program must use  
556.24 state funds to reduce enrollee cost-sharing by increasing the actuarial value of silver level  
556.25 health plans for eligible persons beyond the 73 percent value established in Code of Federal  
556.26 Regulations, title 45, section 156.420(a)(3)(ii), to an actuarial value of 87 percent.

556.27 (b) Paragraph (a) applies beginning for plan year 2024 for eligible individuals expected  
556.28 to have a household income above 200 percent of the federal poverty level but that does  
556.29 not exceed 250 percent of the federal poverty level, for the benefit year for which coverage  
556.30 is requested.

556.31 (c) Beginning for plan year 2026, the cost-sharing reduction program applies for eligible  
556.32 individuals expected to have a household income above 250 percent of the federal poverty  
557.1 level but that does not exceed 300 percent of the federal poverty level, for the benefit year  
557.2 for which coverage is requested. Under this paragraph, the cost-sharing reduction program  
557.3 applies by increasing the actuarial value of silver level health plans for eligible persons to  
557.4 the 73 percent actuarial value established in Code of Federal Regulations, title 45, section  
557.5 156.420(a)(3)(ii).

557.6 Subd. 3. **Administration.** The board, when administering the program, must:

557.7 (1) allow eligible persons to enroll in a silver level health plan with a state-funded  
557.8 cost-sharing reduction;

557.9 (2) modify the MNsure shopping tool to display the total cost-sharing reduction benefit  
557.10 available to individuals eligible under this section; and

557.11 (3) reimburse health carriers on a quarterly basis for the cost to the health plan providing  
557.12 the state-funded cost-sharing reductions.

557.13 **EFFECTIVE DATE.** This section is effective the day following final enactment.

557.14 Sec. 11. **[62V.13] EASY ENROLLMENT HEALTH INSURANCE OUTREACH**  
557.15 **PROGRAM.**

557.16 Subdivision 1. **Establishment.** The board, in cooperation with the commissioner of  
557.17 revenue, must establish the easy enrollment health insurance outreach program to:

557.18 (1) reduce the number of uninsured Minnesotans and increase access to affordable health  
557.19 insurance coverage;

557.20 (2) allow the commissioner of revenue to provide return information, at the request of  
557.21 the taxpayer, to MNsure to provide the taxpayer with information about the potential  
557.22 eligibility for financial assistance and health insurance enrollment options through MNsure;

68.3 (d) The board shall establish procedures for determining an individual's eligibility for  
68.4 the subsidy and providing payments to a health carrier for any eligible individuals enrolled  
68.5 in the carrier's gold level health plans.

557.23 (3) allow MNsure to estimate taxpayer potential eligibility for financial assistance for  
557.24 health insurance coverage; and

557.25 (4) allow MNsure to conduct targeted outreach to assist interested taxpayer households  
557.26 in applying for and enrolling in affordable health insurance options through MNsure,  
557.27 including connecting interested taxpayer households with a navigator or broker for free  
557.28 enrollment assistance.

557.29 Subd. 2. **Screening for eligibility for insurance assistance.** Upon receipt of and based  
557.30 on return information received from the commissioner of revenue under section 270B.14,  
557.31 subdivision 22, MNsure may make a projected assessment on whether the interested  
558.1 taxpayer's household may qualify for a financial assistance program for health insurance  
558.2 coverage.

558.3 Subd. 3. **Outreach letter and special enrollment period.** (a) MNsure must provide a  
558.4 written letter of the projected assessment under subdivision 2 to a taxpayer who indicates  
558.5 to the commissioner of revenue that the taxpayer is interested in obtaining information on  
558.6 access to health insurance.

558.7 (b) MNsure must allow a special enrollment period for taxpayers who receive the outreach  
558.8 letter in paragraph (a) and are determined eligible to enroll in a qualified health plan through  
558.9 MNsure. The triggering event for the special enrollment period is the day the outreach letter  
558.10 under this subdivision is mailed to the taxpayer. An eligible individual, and their dependents,  
558.11 have 65 days from the triggering event to select a qualifying health plan and coverage for  
558.12 the qualifying health plan is effective the first day of the month after plan selection.

558.13 (c) Taxpayers who have a member of the taxpayer's household currently enrolled in a  
558.14 qualified health plan through MNsure are not eligible for the special enrollment under  
558.15 paragraph (b).

558.16 (d) MNsure must provide information about the easy enrollment health insurance outreach  
558.17 program and the special enrollment period described in this subdivision to the general public.

558.18 Subd. 4. **Appeals.** (a) Projected eligibility assessments for financial assistance under  
558.19 this section are not appealable.

558.20 (b) Qualification for the special enrollment period under this section is appealable to  
558.21 MNsure under this chapter and Minnesota Rules, chapter 7700.

558.22 **EFFECTIVE DATE.** This section is effective for taxable years beginning after December  
558.23 31, 2023, and applies to health plans offered, issued, or sold on or after January 1, 2024.

558.24 Sec. 12. Minnesota Statutes 2022, section 256.962, subdivision 5, is amended to read:

558.25 Subd. 5. **Incentive program.** Beginning January 1, 2008, the commissioner shall establish  
558.26 an incentive program for organizations and licensed insurance producers under chapter 60K  
558.27 that directly identify and assist potential enrollees in filling out and submitting an application.  
558.28 For each applicant who is successfully enrolled in MinnesotaCare or medical assistance,

558.29 the commissioner, within the available appropriation, shall pay the organization or licensed  
558.30 insurance producer a ~~\$70~~ \$100 application assistance bonus. The organization or licensed  
558.31 insurance producer may provide an applicant a gift certificate or other incentive upon  
558.32 enrollment.

559.1 **EFFECTIVE DATE.** This section is effective July 1, 2023.

68.6 Sec. 10. **[256.9631] DIRECT PAYMENT SYSTEM FOR MEDICAL ASSISTANCE**  
68.7 **AND MINNESOTACARE.**

68.8 Subdivision 1. **Direct payment system established.** (a) The commissioner shall establish  
68.9 a direct payment system to deliver services to eligible individuals, in order to achieve better  
68.10 health outcomes and reduce the cost of health care for the state. Under this system, eligible  
68.11 individuals shall receive services through the medical assistance fee-for-service system,  
68.12 county-based purchasing plans, or county-owned health maintenance organizations. The  
68.13 commissioner shall implement the direct payment system beginning January 1, 2027.

68.14 (b) Persons who do not meet the definition of eligible individual shall continue to receive  
68.15 services from managed care and county-based purchasing plans under sections 256B.69  
68.16 and 256B.692, subject to the opt-out provision under section 256B.69, subdivision 28,  
68.17 paragraph (c), for persons who are certified as blind or having a disability, and the exemptions  
68.18 from managed care enrollment listed in section 256B.69, subdivision 4, paragraph (b).

68.19 Subd. 2. **Definitions.** (a) For purposes of this section, the following definitions apply.

68.20 (b) "Eligible individuals" means: (1) qualified medical assistance enrollees, defined as  
68.21 persons eligible for medical assistance as families and children and adults without children  
68.22 eligible under section 256B.055, subdivision 15; and (2) all MinnesotaCare enrollees.

68.23 (c) "Qualified hospital provider" means a nonstate government teaching hospital with  
68.24 high medical assistance utilization and a level 1 trauma center, and all of the hospital's  
68.25 owned or affiliated health care professionals, ambulance services, sites, and clinics.

68.26 Subd. 3. **Managed care service delivery.** (a) In counties that choose to operate a  
68.27 county-based purchasing plan under section 256B.692, the commissioner shall permit those  
68.28 counties, in a timely manner, to establish a new county-based purchasing plan or participate  
68.29 in an existing county-based purchasing plan.

68.30 (b) In counties that choose to operate a county-owned health maintenance organization  
68.31 under section 256B.69, the commissioner shall permit those counties to establish a new  
68.32 county-owned and operated health maintenance organization or continue serving enrollees  
68.33 through an existing county-owned and operated health maintenance organization.

69.1 (c) County-based purchasing plans and county-owned health maintenance organizations  
69.2 shall be reimbursed at the capitation rate determined under sections 256B.69 and 256B.692.



69.3 (d) The commissioner shall allow eligible individuals the opportunity to opt out of  
69.4 enrollment in a county-based purchasing plan or county-owned health maintenance  
69.5 organization.

69.6 Subd. 4. **Fee-for-service reimbursement.** (a) The commissioner shall reimburse health  
69.7 care providers directly for all medical assistance and MinnesotaCare covered services  
69.8 provided to eligible individuals, using the fee-for-service payment methods specified in  
69.9 chapters 256, 256B, 256R, and 256S.

69.10 (b) The commissioner shall ensure that payments under this section to a qualified hospital  
69.11 provider are equivalent to the payments that would have been received based on managed  
69.12 care direct payment arrangements. If necessary, a qualified hospital provider may use a  
69.13 county-owned health maintenance organization to receive direct payments as described in  
69.14 section 256B.1973.

69.15 Subd. 5. **Termination of managed care contracts.** The commissioner shall terminate  
69.16 managed care contracts for eligible individuals under sections 256B.69, 256L.12, and  
69.17 256L.121 by December 31, 2026, except that the commissioner shall continue to contract  
69.18 with county-based purchasing plans and county-owned health maintenance organizations,  
69.19 as provided under this section.

69.20 Subd. 6. **System development and administration.** (a) The commissioner, under the  
69.21 direct payment system, shall:

69.22 (1) provide benefits management, claims processing, and enrollee support services;

69.23 (2) coordinate operation of the direct payment system with county agencies and MNsure,  
69.24 and with service delivery to medical assistance enrollees who are age 65 or older, blind, or  
69.25 have disabilities, or who are exempt from managed care enrollment under section 256B.69,  
69.26 subdivision 4, paragraph (b);

69.27 (3) establish and maintain provider payment rates at levels sufficient to ensure  
69.28 high-quality care and enrollee access to covered health care services;

69.29 (4) develop and monitor quality measures for health care service delivery; and

69.30 (5) develop and implement provider incentives and innovative methods of health care  
69.31 delivery, to ensure the efficient provision of high-quality care and reduce health care  
69.32 disparities.

70.1 (b) This section does not prohibit the commissioner from seeking legislative and federal  
70.2 approval for demonstration projects to ensure access to care or improve health care quality.

70.3 (c) The commissioner may contract with an administrator to administer the direct payment  
70.4 system.

70.5 Subd. 7. **Implementation plan.** (a) The commissioner shall present an implementation  
70.6 plan for the direct payment system to the chairs and ranking minority members of the

- 70.7 legislative committees with jurisdiction over health care policy and finance by January 15,  
70.8 2025. The commissioner may contract for technical assistance in developing the  
70.9 implementation plan and conducting related studies and analysis.
- 70.10 (b) The implementation plan must include:
- 70.11 (1) a timeline for the development and implementation of the direct payment system;  
70.12 (2) the procedures to be used to ensure continuity of care for enrollees who transition  
70.13 from managed care to fee-for-service;
- 70.14 (3) any changes to fee-for-service payment rates that the commissioner determines are  
70.15 necessary to ensure provider access and high-quality care, and reduce health disparities;
- 70.16 (4) recommendations on ensuring effective care coordination under the direct payment  
70.17 system, especially for enrollees with complex medical conditions, who face socioeconomic  
70.18 barriers to receiving care, or who are from underserved populations that experience health  
70.19 disparities;
- 70.20 (5) recommendations on whether the direct payment system should provide supplemental  
70.21 payments for care coordination, including:
- 70.22 (i) the provider types eligible for supplemental payments and funding for outreach;  
70.23 (ii) procedures to coordinate supplemental payments with existing supplemental or  
70.24 cost-based payment methods or to replace these existing methods; and
- 70.25 (iii) procedures to align care coordination initiatives funded through supplemental  
70.26 payments under this section with existing care coordination initiatives;
- 70.27 (6) recommendations on whether the direct payment system should include funding to  
70.28 providers for outreach initiatives to patients who, because of mental illness, homelessness,  
70.29 or other circumstances, are unlikely to obtain needed care and treatment;
- 70.30 (7) recommendations on whether and how the direct payment system should be expanded  
70.31 to deliver services and care coordination to persons who are age 65 or older, are blind, or  
70.32 have a disability;
- 71.1 (8) procedures to compensate providers for any loss of savings from the federal 340B  
71.2 Drug Pricing Program; and
- 71.3 (9) recommendations for statutory changes necessary to implement the direct payment  
71.4 system.
- 71.5 (c) In developing the implementation plan, the commissioner shall:
- 71.6 (1) calculate the projected cost of a direct payment system relative to the cost of the  
71.7 current system;

559.2       Sec. 13. Minnesota Statutes 2022, section 256B.04, is amended by adding a subdivision  
559.3 to read:

559.4       Subd. 26. **Disenrollment under medical assistance and MinnesotaCare.** (a) The  
559.5 commissioner shall regularly update mailing addresses and other contact information for  
559.6 medical assistance and MinnesotaCare enrollees in cases of returned mail and nonresponse  
559.7 using information available through managed care and county-based purchasing plans, state  
559.8 health and human services programs, and other sources.

559.9       (b) The commissioner shall not disenroll an individual from medical assistance or  
559.10 MinnesotaCare in cases of returned mail until the commissioner makes at least two attempts  
559.11 by phone, email, or other methods to contact the individual. The commissioner may disenroll  
559.12 the individual after providing no less than 30 days for the individual to respond to the most  
559.13 recent contact attempt.

559.14       Sec. 14. Minnesota Statutes 2022, section 256B.056, subdivision 7, is amended to read:

559.15       Subd. 7. **Period of eligibility.** (a) Eligibility is available for the month of application  
559.16 and for three months prior to application if the person was eligible in those prior months.  
559.17 A redetermination of eligibility must occur every 12 months.

559.18       (b) Notwithstanding any other law to the contrary:

559.19       (1) a child under 21 years of age who is determined eligible for medical assistance must  
559.20 remain eligible for a period of 12 months; and

71.8       (2) assess gaps in care coordination under the current medical assistance and  
71.9 MinnesotaCare programs;

71.10       (3) evaluate the effectiveness of approaches other states have taken to coordinate care  
71.11 under a fee-for-service system, including the coordination of care provided to persons who  
71.12 are blind or have disabilities;

71.13       (4) estimate the loss in provider revenues and cost savings under the federal 340B Drug  
71.14 Pricing Program that would result from the elimination of managed care plan contracts  
71.15 under medical assistance and MinnesotaCare, and develop a method to reimburse providers  
71.16 for these potential losses;

71.17       (5) estimate the loss of revenues and cost savings from other payment enhancements  
71.18 based on managed care plan pass-throughs;

71.19       (6) consult with the commissioner of health and the contractor or contractors analyzing  
71.20 the Minnesota Health Plan and other reform models on plan design and assumptions; and

71.21       (7) conduct other analyses necessary to develop the implementation plan.

UES2995-2, ARTICLE 2, SECTION 11, WAS MOVED OUT TO MATCH  
S2995-3, ARTICLE 1, SECTION 5

74.7       Sec. 12. Minnesota Statutes 2022, section 256B.056, subdivision 7, is amended to read:

74.8       Subd. 7. **Period of eligibility.** (a) Eligibility is available for the month of application  
74.9 and for three months prior to application if the person was eligible in those prior months.  
74.10 A redetermination of eligibility must occur every 12 months.

74.11       (b) Notwithstanding any other law to the contrary:

74.12       (1) a child under 19 years of age who is determined eligible for medical assistance must  
74.13 remain eligible for a period of 12 months;

559.21 (2) a child under six years of age who is determined eligible for medical assistance must  
559.22 remain eligible through the month in which the child reaches six years of age.

559.23 (c) A child's eligibility under paragraph (b) may be terminated earlier if:

559.24 (i) the child or the child's representative requests voluntary termination of eligibility;

559.25 (ii) the child ceases to be a resident of this state;

559.26 (iii) the child dies;

559.27 (iv) the child attains the maximum age; or

559.28 (v) the agency determines eligibility was erroneously granted at the most recent eligibility  
559.29 determination due to agency error or fraud, abuse, or perjury attributed to the child or the  
559.30 child's representative.

560.1 ~~(b)~~ (d) For a person eligible for an insurance affordability program as defined in section  
560.2 256B.02, subdivision 19, who reports a change that makes the person eligible for medical  
560.3 assistance, eligibility is available for the month the change was reported and for three months  
560.4 prior to the month the change was reported, if the person was eligible in those prior months.

560.5 **EFFECTIVE DATE.** This section is effective January 1, 2024, or upon federal approval  
560.6 and the implementation of required administrative and systems changes, whichever is later.  
560.7 The commissioner of human services shall notify the revisor of statutes when federal approval  
560.8 is obtained.

560.9 Sec. 15. Minnesota Statutes 2022, section 256B.0631, is amended by adding a subdivision  
560.10 to read:

560.11 Subd. 1a. **Prohibition on cost-sharing and deductibles.** The medical assistance benefit  
560.12 plan must not include cost-sharing or deductibles for any medical assistance recipient or  
560.13 benefit.

74.14 (2) a child 19 years of age and older but under 21 years of age who is determined eligible  
74.15 for medical assistance must remain eligible for a period of 12 months; and

74.16 (3) a child under six years of age who is determined eligible for medical assistance must  
74.17 remain eligible through the month in which the child reaches six years of age.

74.18 (c) A child's eligibility under paragraph (b) may be terminated earlier if:

74.19 (1) the child or the child's representative requests voluntary termination of eligibility;

74.20 (2) the child ceases to be a resident of this state;

74.21 (3) the child dies; or

74.22 (4) the agency determines eligibility was erroneously granted at the most recent eligibility  
74.23 determination due to agency error or fraud, abuse, or perjury attributed to the child or the  
74.24 child's representative.

74.25 ~~(b)~~ (d) For a person eligible for an insurance affordability program as defined in section  
74.26 256B.02, subdivision 19, who reports a change that makes the person eligible for medical  
74.27 assistance, eligibility is available for the month the change was reported and for three months  
74.28 prior to the month the change was reported, if the person was eligible in those prior months.

74.29 **EFFECTIVE DATE.** This section is effective January 1, 2025, or upon federal approval;  
74.30 whichever is later, except that paragraph (b), clause (1), is effective January 1, 2024. The  
75.1 commissioner of human services shall notify the revisor of statutes when federal approval  
75.2 is obtained.

75.3 Sec. 13. Minnesota Statutes 2022, section 256B.0631, subdivision 1, is amended to read:

75.4 Subdivision 1. **Cost-sharing.** (a) Except as provided in subdivision 2, the medical  
75.5 assistance benefit plan shall include the following cost-sharing for all recipients, effective  
75.6 for services provided on or after from September 1, 2011, to December 31, 2023:

75.7 (1) \$3 per nonpreventive visit, except as provided in paragraph (b). For purposes of this  
75.8 subdivision, a visit means an episode of service which is required because of a recipient's  
75.9 symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting  
75.10 by a physician or physician assistant, chiropractor, podiatrist, nurse midwife, advanced  
75.11 practice nurse, audiologist, optician, or optometrist;

75.12 (2) \$3.50 for nonemergency visits to a hospital-based emergency room, except that this  
75.13 co-payment shall be increased to \$20 upon federal approval;

75.14 (3) \$3 per brand-name drug prescription, \$1 per generic drug prescription, and \$1 per  
75.15 prescription for a brand-name multisource drug listed in preferred status on the preferred

560.14 **EFFECTIVE DATE.** This section is effective July 1, 2025, and applies to all medical  
560.15 assistance benefit plans offered, issued, or renewed on or after that date.

75.16 drug list, subject to a \$12 per month maximum for prescription drug co-payments. No  
75.17 co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness;

75.18 (4) a family deductible equal to \$2.75 per month per family and adjusted annually by  
75.19 the percentage increase in the medical care component of the CPI-U for the period of  
75.20 September to September of the preceding calendar year, rounded to the next higher five-cent  
75.21 increment; and

75.22 (5) total monthly cost-sharing must not exceed five percent of family income. For  
75.23 purposes of this paragraph, family income is the total earned and unearned income of the  
75.24 individual and the individual's spouse, if the spouse is enrolled in medical assistance and  
75.25 also subject to the five percent limit on cost-sharing. This paragraph does not apply to  
75.26 premiums charged to individuals described under section 256B.057, subdivision 9.

75.27 (b) Recipients of medical assistance are responsible for all co-payments and deductibles  
75.28 in this subdivision.

75.29 (c) Notwithstanding paragraph (b), the commissioner, through the contracting process  
75.30 under sections 256B.69 and 256B.692, may allow managed care plans and county-based  
75.31 purchasing plans to waive the family deductible under paragraph (a), clause (4). The value  
75.32 of the family deductible shall not be included in the capitation payment to managed care  
76.1 plans and county-based purchasing plans. Managed care plans and county-based purchasing  
76.2 plans shall certify annually to the commissioner the dollar value of the family deductible.

76.3 (d) Notwithstanding paragraph (b), the commissioner may waive the collection of the  
76.4 family deductible described under paragraph (a), clause (4), from individuals and allow  
76.5 long-term care and waived service providers to assume responsibility for payment.

76.6 (e) Notwithstanding paragraph (b), the commissioner, through the contracting process  
76.7 under section 256B.0756 shall allow the pilot program in Hennepin County to waive  
76.8 co-payments. The value of the co-payments shall not be included in the capitation payment  
76.9 amount to the integrated health care delivery networks under the pilot program.

76.10 (f) For services provided on or after January 1, 2024, the medical assistance benefit plan  
76.11 must not include cost-sharing or deductibles for any medical assistance recipient or benefit.

76.12 Sec. 14. Minnesota Statutes 2022, section 256B.0631, subdivision 3, is amended to read:

76.13 Subd. 3. **Collection.** (a) The medical assistance reimbursement to the provider shall be  
76.14 reduced by the amount of the co-payment or deductible, except that reimbursements shall  
76.15 not be reduced;

560.16     Sec. 16. Minnesota Statutes 2022, section 256L.04, subdivision 7a, is amended to read:

560.17             Subd. 7a. **Ineligibility.** Adults whose income is greater than the limits established under

560.18 this section may not enroll in the MinnesotaCare program, except as provided in subdivision

560.19 15.

76.16             (1) once a recipient has reached the \$12 per month maximum for prescription drug

76.17 co-payments; or

76.18             (2) for a recipient who has met their monthly five percent cost-sharing limit.

76.19             (b) The provider collects the co-payment or deductible from the recipient. Providers

76.20 may not deny services to recipients who are unable to pay the co-payment or deductible.

76.21             ~~(c) Medical assistance reimbursement to fee-for-service providers and payments to~~

76.22 ~~managed care plans shall not be increased as a result of the removal of co-payments or~~

76.23 ~~deductibles effective on or after January 1, 2009.~~

76.24             **EFFECTIVE DATE.** This section is effective January 1, 2024.

UES2995-2, ARTICLE 2, SECTION 15, WAS MOVED OUT TO MATCH S2995-3, ARTICLE 1, SECTION 25

UES2995-2, ARTICLE 2, SECTION 16, WAS MOVED OUT TO MATCH S2995-3, ARTICLE 1, SECTION 27

UES2995-2, ARTICLE 2, SECTION 17, WAS MOVED OUT TO MATCH S2995-3, ARTICLE 1, SECTION 30

UES2995-2, ARTICLE 2, SECTION 18, WAS MOVED OUT TO MATCH S2995-3, ARTICLE 1, SECTION 31

UES2995-2, ARTICLE 2, SECTION 19, WAS MOVED OUT TO MATCH S2995-3, ARTICLE 1, SECTION 32

UES2995-2, ARTICLE 2, SECTION 20, WAS MOVED OUT TO MATCH S2995-3, ARTICLE 1, SECTION 33

84.3             Sec. 21. Minnesota Statutes 2022, section 256L.04, subdivision 1c, is amended to read:

84.4             Subd. 1c. **General requirements.** To be eligible for MinnesotaCare, a person must meet

84.5 the eligibility requirements of this section. A person eligible for MinnesotaCare ~~shall~~ with

84.6 a family income of less than or equal to 200 percent of the federal poverty guidelines must

84.7 not be considered a qualified individual under section 1312 of the Affordable Care Act, and

84.8 is not eligible for enrollment in a qualified health plan offered through MNsure under chapter

84.9 62V.

84.10             **EFFECTIVE DATE.** This section is effective January 1, 2027, or upon federal approval,

84.11 whichever is later. The commissioner of human services shall notify the revisor of statutes

84.12 when federal approval is obtained.

84.13             Sec. 22. Minnesota Statutes 2022, section 256L.04, subdivision 7a, is amended to read:

84.14             Subd. 7a. **Ineligibility.** Adults whose income is greater than the limits established under

84.15 this section may not enroll in the MinnesotaCare program, except as provided in subdivision

84.16 15.

560.20 **EFFECTIVE DATE.** This section is effective January 1, 2027, or upon federal approval,  
 560.21 whichever is later, subject to certification under section 32. The commissioner of human  
 560.22 services shall notify the revisor of statutes when federal approval is obtained.

560.23 Sec. 17. Minnesota Statutes 2022, section 256L.04, subdivision 10, is amended to read:

560.24 Subd. 10. **Citizenship requirements.** (a) Eligibility for MinnesotaCare is limited to  
 560.25 citizens or nationals of the United States and lawfully present noncitizens as defined in  
 560.26 Code of Federal Regulations, title 8, section 103.12. Undocumented noncitizens, with the  
 560.27 exception of children under 19 years of age, are ineligible for MinnesotaCare. For purposes  
 560.28 of this subdivision, an undocumented noncitizen is an individual who resides in the United  
 560.29 States without the approval or acquiescence of the United States Citizenship and Immigration  
 560.30 Services. Families with children who are citizens or nationals of the United States must  
 560.31 cooperate in obtaining satisfactory documentary evidence of citizenship or nationality  
 561.1 according to the requirements of the federal Deficit Reduction Act of 2005, Public Law  
 561.2 109-171.

561.3 (b) Notwithstanding subdivisions 1 and 7, eligible persons include families and  
 561.4 individuals who are lawfully present and ineligible for medical assistance by reason of  
 561.5 immigration status and who have incomes equal to or less than 200 percent of federal poverty  
 561.6 guidelines.

561.7 **EFFECTIVE DATE.** This section is effective January 1, 2025.

561.8 Sec. 18. Minnesota Statutes 2022, section 256L.04, is amended by adding a subdivision  
 561.9 to read:

561.10 Subd. 15. **Persons eligible for public option.** (a) Families and individuals with income  
 561.11 above the maximum income eligibility limit specified in subdivision 1 or 7 but who meet  
 561.12 all other MinnesotaCare eligibility requirements are eligible for MinnesotaCare. All other  
 561.13 provisions of this chapter apply unless otherwise specified.

561.14 (b) Families and individuals may enroll in MinnesotaCare under this subdivision only  
 561.15 during an annual open enrollment period or special enrollment period, as designated by  
 561.16 MNsure in compliance with Code of Federal Regulations, title 45, parts 155.410 and 155.420.

561.17 **EFFECTIVE DATE.** This section is effective January 1, 2027, or upon federal approval,  
 561.18 whichever is later, subject to certification under section 32. The commissioner of human  
 561.19 services shall notify the revisor of statutes when federal approval is obtained.

561.20 Sec. 19. Minnesota Statutes 2022, section 256L.07, subdivision 1, is amended to read:

561.21 Subdivision 1. **General requirements.** Individuals enrolled in MinnesotaCare under  
 561.22 section 256L.04, subdivision 1, and individuals enrolled in MinnesotaCare under section  
 561.23 256L.04, subdivision 7, whose income increases above 200 percent of the federal poverty  
 561.24 guidelines, are no longer eligible for the program and shall must be disenrolled by the  
 561.25 commissioner, unless the individuals continue MinnesotaCare enrollment through the public

84.17 **EFFECTIVE DATE.** This section is effective January 1, 2027, or upon federal approval,  
 84.18 whichever is later. The commissioner of human services shall notify the revisor of statutes  
 84.19 when federal approval is obtained.

84.20 Sec. 23. Minnesota Statutes 2022, section 256L.04, subdivision 10, is amended to read:

84.21 Subd. 10. **Citizenship requirements.** (a) Eligibility for MinnesotaCare is limited  
 84.22 available to citizens or nationals of the United States and, lawfully present noncitizens as  
 84.23 defined in Code of Federal Regulations, title 8, section 103.12.: and undocumented  
 84.24 noncitizens are ineligible for MinnesotaCare. For purposes of this subdivision, an  
 84.25 undocumented noncitizen is an individual who resides in the United States without the  
 84.26 approval or acquiescence of the United States Citizenship and Immigration Services. Families  
 84.27 with children who are citizens or nationals of the United States must cooperate in obtaining  
 84.28 satisfactory documentary evidence of citizenship or nationality according to the requirements  
 84.29 of the federal Deficit Reduction Act of 2005, Public Law 109-171.

84.30 (b) Notwithstanding subdivisions 1 and 7, eligible persons include families and  
 84.31 individuals who are lawfully present and ineligible for medical assistance by reason of  
 84.32 immigration status and who have incomes equal to or less than 200 percent of federal poverty  
 85.1 guidelines, except that these persons may be eligible for emergency medical assistance  
 85.2 under section 256B.06, subdivision 4.

85.3 **EFFECTIVE DATE.** This section is effective January 1, 2025.

85.4 Sec. 24. Minnesota Statutes 2022, section 256L.04, is amended by adding a subdivision  
 85.5 to read:

85.6 Subd. 15. **Persons eligible for public option.** (a) Families and individuals with income  
 85.7 above the maximum income eligibility limit specified in subdivision 1 or 7 but who meet  
 85.8 all other MinnesotaCare eligibility requirements are eligible for MinnesotaCare. All other  
 85.9 provisions of this chapter apply unless otherwise specified.

85.10 (b) Families and individuals may enroll in MinnesotaCare under this subdivision only  
 85.11 during an annual open enrollment period or special enrollment period, as designated by  
 85.12 MNsure in compliance with Code of Federal Regulations, title 45, parts 155.410 and 155.420.

85.13 **EFFECTIVE DATE.** This section is effective January 1, 2027, or upon federal approval,  
 85.14 whichever is later. The commissioner of human services shall notify the revisor of statutes  
 85.15 when federal approval is obtained.

85.16 Sec. 25. Minnesota Statutes 2022, section 256L.07, subdivision 1, is amended to read:

85.17 Subdivision 1. **General requirements.** Individuals enrolled in MinnesotaCare under  
 85.18 section 256L.04, subdivision 1, and individuals enrolled in MinnesotaCare under section  
 85.19 256L.04, subdivision 7, whose income increases above 200 percent of the federal poverty  
 85.20 guidelines, are no longer eligible for the program and shall must be disenrolled by the  
 85.21 commissioner, unless the individuals continue MinnesotaCare enrollment through the public



561.26 option under section 256L.04, subdivision 15. For persons disenrolled under this subdivision,  
561.27 MinnesotaCare coverage terminates the last day of the calendar month in which the  
561.28 commissioner sends advance notice according to Code of Federal Regulations, title 42,  
561.29 section 431.211, that indicates the income of a family or individual exceeds program income  
561.30 limits.

562.1 **EFFECTIVE DATE.** This section is effective January 1, 2027, or upon federal approval,  
562.2 whichever is later, subject to certification under section 32. The commissioner of human  
562.3 services shall notify the revisor of statutes when federal approval is obtained.

562.4 Sec. 20. Minnesota Statutes 2022, section 256L.15, subdivision 2, is amended to read:

562.5 Subd. 2. **Sliding fee scale; monthly individual or family income.** (a) The commissioner  
562.6 shall establish a sliding fee scale to determine the percentage of monthly individual or family  
562.7 income that households at different income levels must pay to obtain coverage through the  
562.8 MinnesotaCare program. The sliding fee scale must be based on the enrollee's monthly  
562.9 individual or family income.

562.10 ~~(b) Beginning January 1, 2014, MinnesotaCare enrollees shall pay premiums according~~  
562.11 ~~to the premium scale specified in paragraph (d).~~

562.12 ~~(e) (b) Paragraph (b) (a) does not apply to:~~

562.13 ~~(1) children 20 years of age or younger; and~~

562.14 ~~(2) individuals with household incomes below 35 percent of the federal poverty~~  
562.15 ~~guidelines.~~

562.16 ~~(d) The following premium scale is established for each individual in the household who~~  
562.17 ~~is 21 years of age or older and enrolled in MinnesotaCare:~~

562.18	<del>Federal Poverty Guideline</del>	<del>Less than</del>	<del>Individual Premium</del>
562.19	<del>Greater than or Equal to</del>		<del>Amount</del>
562.20	35%	55%	\$4
562.21	55%	80%	\$6
562.22	80%	90%	\$8
562.23	90%	100%	\$10
562.24	100%	110%	\$12
562.25	110%	120%	\$14
562.26	120%	130%	\$15

85.22 option under section 256L.04, subdivision 15. For persons disenrolled under this subdivision,  
85.23 MinnesotaCare coverage terminates the last day of the calendar month in which the  
85.24 commissioner sends advance notice according to Code of Federal Regulations, title 42,  
85.25 section 431.211, that indicates the income of a family or individual exceeds program income  
85.26 limits.

85.27 **EFFECTIVE DATE.** This section is effective January 1, 2027, or upon federal approval,  
85.28 whichever is later. The commissioner of human services shall notify the revisor of statutes  
85.29 when federal approval is obtained.

86.1 Sec. 26. Minnesota Statutes 2022, section 256L.15, subdivision 2, is amended to read:

86.2 Subd. 2. **Sliding fee scale; monthly individual or family income.** (a) The commissioner  
86.3 shall establish a sliding fee scale to determine the percentage of monthly individual or family  
86.4 income that households at different income levels must pay to obtain coverage through the  
86.5 MinnesotaCare program. The sliding fee scale must be based on the enrollee's monthly  
86.6 individual or family income.

86.7 ~~(b) Beginning January 1, 2014, MinnesotaCare enrollees shall pay premiums according~~  
86.8 ~~to the premium scale specified in paragraph (d).~~

86.9 ~~(e) (b) Paragraph (b) (a) does not apply to:~~

86.10 ~~(1) children 20 years of age or younger; and~~

86.11 ~~(2) individuals with household incomes below 35 percent of the federal poverty~~  
86.12 ~~guidelines.~~

86.13 ~~(d) The following premium scale is established for each individual in the household who~~  
86.14 ~~is 21 years of age or older and enrolled in MinnesotaCare:~~

86.15	<del>Federal Poverty Guideline</del>	<del>Less than</del>	<del>Individual Premium</del>
86.16	<del>Greater than or Equal to</del>		<del>Amount</del>
86.17	35%	55%	\$4
86.18	55%	80%	\$6
86.19	80%	90%	\$8
86.20	90%	100%	\$10
86.21	100%	110%	\$12
86.22	110%	120%	\$14
86.23	120%	130%	\$15

562.27	<del>130%</del>	<del>140%</del>	\$16
562.28	<del>140%</del>	<del>150%</del>	\$25
562.29	<del>150%</del>	<del>160%</del>	\$37
562.30	<del>160%</del>	<del>170%</del>	\$44
562.31	<del>170%</del>	<del>180%</del>	\$52
562.32	<del>180%</del>	<del>190%</del>	\$61
562.33	<del>190%</del>	<del>200%</del>	\$71
562.34	<del>200%</del>		\$80

563.1 ~~(e)~~ (c) Beginning January 1, 2021, 2024, the commissioner shall continue to charge  
563.2 premiums in accordance with the simplified premium scale established to comply with the  
563.3 American Rescue Plan Act of 2021, in effect from January 1, 2021, through December 31,  
563.4 2025, for families and individuals eligible under section 256L.04, subdivisions 1 and 7. The  
563.5 commissioner shall adjust the premium scale ~~established under paragraph (d) as needed~~ to  
563.6 ensure that premiums do not exceed the amount that an individual would have been required  
563.7 to pay if the individual was enrolled in an applicable benchmark plan in accordance with  
563.8 the Code of Federal Regulations, title 42, section 600.505 (a)(1).

563.9 (d) The commissioner shall establish a sliding premium scale for persons eligible through  
563.10 the public option under section 256L.04, subdivision 15. Beginning January 1, 2027, persons  
563.11 eligible through the public option shall pay premiums according to this premium scale.  
563.12 Persons eligible through the public option who are 20 years of age or younger are exempt  
563.13 from paying premiums.

563.14 **EFFECTIVE DATE.** This section is effective January 1, 2024, and certification under  
563.15 section 32 is not required, except that paragraph (d) is effective January 1, 2027, or upon  
563.16 federal approval, whichever is later, subject to certification under section 32. The  
563.17 commissioner of human services shall notify the revisor of statutes when federal approval  
563.18 is obtained.

563.19 Sec. 21. Minnesota Statutes 2022, section 270B.14, is amended by adding a subdivision  
563.20 to read:

563.21 Subd. 22. **Disclosure to MNsure board.** The commissioner may disclose a return or  
563.22 return information to the MNsure board if a taxpayer makes the designation under section  
563.23 290.433 on an income tax return filed with the commissioner. The commissioner must only  
563.24 disclose data necessary to provide the taxpayer with information about the potential eligibility  
563.25 for financial assistance and health insurance enrollment options under section 62V.13.

86.24	<del>130%</del>	<del>140%</del>	\$16
86.25	<del>140%</del>	<del>150%</del>	\$25
86.26	<del>150%</del>	<del>160%</del>	\$37
86.27	<del>160%</del>	<del>170%</del>	\$44
86.28	<del>170%</del>	<del>180%</del>	\$52
86.29	<del>180%</del>	<del>190%</del>	\$61
86.30	<del>190%</del>	<del>200%</del>	\$71
86.31	<del>200%</del>		\$80

86.32 ~~(e)~~ (c) Beginning January 1, 2021, 2024, the commissioner shall continue to charge  
86.33 premiums in accordance with the simplified premium scale established to comply with the  
86.34 American Rescue Plan Act of 2021, in effect from January 1, 2021, through December 31,  
87.1 2025, for families and individuals eligible under section 256L.04, subdivisions 1 and 7. The  
87.2 commissioner shall adjust the premium scale ~~established under paragraph (d) as needed~~ to  
87.3 ensure that premiums do not exceed the amount that an individual would have been required  
87.4 to pay if the individual was enrolled in an applicable benchmark plan in accordance with  
87.5 the Code of Federal Regulations, title 42, section 600.505 (a)(1).

87.6 (d) The commissioner shall establish a sliding premium scale for persons eligible through  
87.7 the public option under section 256L.04, subdivision 15. Beginning January 1, 2027, persons  
87.8 eligible through the public option shall pay premiums according to this premium scale.  
87.9 Persons eligible through the public option who are 20 years of age or younger are exempt  
87.10 from paying premiums.

87.11 **EFFECTIVE DATE.** This section is effective January 1, 2024, except that paragraph  
87.12 (d) is effective January 1, 2027, or upon federal approval, whichever is later. The  
87.13 commissioner of human services shall notify the revisor of statutes when federal approval  
87.14 is obtained.

563.26 **EFFECTIVE DATE.** This section is effective the day following final enactment.

563.27 Sec. 22. **[290.433] EASY ENROLLMENT HEALTH INSURANCE OUTREACH**  
563.28 **PROGRAM CHECKOFF.**

563.29 Subdivision 1. **Taxpayer designation.** Any individual who files an income tax return  
563.30 may designate on their original return a request that the commissioner provide their return  
563.31 information to the MNsure board for purposes of providing the individual with information  
563.32 about potential eligibility for financial assistance and health insurance enrollment options  
564.1 under section 62V.13, to the extent necessary to administer the easy enrollment health  
564.2 insurance outreach program.

564.3 Subd. 2. **Form.** The commissioner shall notify filers of their ability to make the  
564.4 designation in subdivision 1 on their income tax return.

564.5 **EFFECTIVE DATE.** This section is effective for taxable years beginning after December  
564.6 31, 2023.

564.7 Sec. 23. **DIRECTION TO MNSURE BOARD AND COMMISSIONER.**

564.8 The MNsure board and the commissioner of the Department of Revenue must develop  
564.9 and implement systems, policies, and procedures that encourage, facilitate, and streamline  
564.10 data sharing, projected eligibility assessments, and notice to taxpayers to achieve the purpose  
564.11 of the easy enrollment health insurance outreach program under Minnesota Statutes, section  
564.12 62V.13, for operation beginning with tax year 2023.

564.13 Sec. 24. **RECOMMENDATIONS; OFFICE OF PATIENT PROTECTION.**

564.14 (a) The commissioners of human services, health, and commerce and the MNsure board  
564.15 shall submit to the health care affordability board and the chairs and ranking minority  
564.16 members of the legislative committees with primary jurisdiction over health and human  
564.17 services finance and policy and commerce by January 15, 2024, a report on the organization  
564.18 and duties of the Office of Patient Protection, to be established under Minnesota Statutes,  
564.19 section 62J.89, subdivision 4. The report must include recommendations on how the office  
564.20 shall:

564.21 (1) coordinate or consolidate within the office existing state agency patient protection  
564.22 activities, including but not limited to the activities of ombudsman offices and the MNsure  
564.23 board;

564.24 (2) enforce standards and procedures under Minnesota Statutes, chapter 62M, for  
564.25 utilization review organizations;

564.26 (3) work with private sector and state agency consumer assistance programs to assist  
564.27 consumers with questions or concerns relating to public programs and private insurance  
564.28 coverage;

564.29 (4) establish and implement procedures to assist consumers aggrieved by restrictions on  
564.30 patient choice, denials of services, and reductions in quality of care resulting from any final  
564.31 action by a payer or provider; and

565.1 (5) make health plan company quality of care and patient satisfaction information and  
565.2 other information collected by the office readily accessible to consumers on the board's  
565.3 website.

565.4 (b) The commissioners and the MNsure board shall consult with stakeholders as they  
565.5 develop the recommendations. The stakeholders consulted must include but are not limited  
565.6 to organizations and individuals representing: underserved communities; persons with  
565.7 disabilities; low-income Minnesotans; senior citizens; and public and private sector health  
565.8 plan enrollees, including persons who purchase coverage through MNsure, health plan  
565.9 companies, and public and private sector purchasers of health coverage.

565.10 (c) The commissioners and the MNsure board may contract with a third party to develop  
565.11 the report and recommendations.

565.12 Sec. 25. TRANSITION TO MINNESOTACARE PUBLIC OPTION.

565.13 (a) The commissioner of human services must continue to administer MinnesotaCare  
565.14 as a basic health program in accordance with Minnesota Statutes, section 256L.02,  
565.15 subdivision 5, and must seek federal waivers, approvals, and law changes as required under  
565.16 section 26.

565.17 (b) The commissioner must present an implementation plan for the MinnesotaCare public  
565.18 option under Minnesota Statutes, section 256L.04, subdivision 15, to the chairs and ranking  
565.19 minority members of the legislative committees with jurisdiction over health care policy  
565.20 and finance by December 15, 2024. The plan must include:

565.21 (1) recommendations for any changes to the MinnesotaCare public option necessary to  
565.22 continue federal basic health program funding or to receive other federal funding;

565.23 (2) recommendations for ensuring sufficient provider participation in MinnesotaCare;

565.24 (3) estimates of state costs related to the MinnesotaCare public option;

565.25 (4) a description of the proposed premium scale for persons eligible through the public  
565.26 option, including an analysis of the extent to which the proposed premium scale;

565.27 (i) ensures affordable premiums for persons across the income spectrum enrolled under  
565.28 the public option; and

565.29 (ii) avoids premium cliffs for persons transitioning to and enrolled under the public  
565.30 option; and

87.15 Sec. 27. TRANSITION TO MINNESOTACARE PUBLIC OPTION.

87.16 (a) The commissioner of human services shall continue to administer MinnesotaCare  
87.17 as a basic health program in accordance with Minnesota Statutes, section 256L.02,  
87.18 subdivision 5.

87.19 (b) The commissioner shall present an implementation plan for the MinnesotaCare public  
87.20 option under Minnesota Statutes, section 256L.04, subdivision 15, to the chairs and ranking  
87.21 minority members of the legislative committees with jurisdiction over health care policy  
87.22 and finance by January 15, 2025. The plan must include:

87.23 (1) recommendations for any changes to the MinnesotaCare public option necessary to  
87.24 continue federal basic health program funding or to receive other federal funding;

87.25 (2) recommendations for ensuring sufficient provider participation in MinnesotaCare;

87.26 (3) estimates of state costs related to the MinnesotaCare public option;

87.27 (4) a description of the proposed premium scale for persons eligible through the public  
87.28 option, including an analysis of the extent to which the proposed premium scale;

87.29 (i) ensures affordable premiums for persons across the income spectrum enrolled under  
87.30 the public option; and

87.31 (ii) avoids premium cliffs for persons transitioning to and enrolled under the public  
87.32 option; and

566.1 (5) draft legislation that includes any additional policy and conforming changes necessary  
 566.2 to implement the MinnesotaCare public option and the implementation plan  
 566.3 recommendations.

566.4 (c) The commissioner shall present to the chairs and ranking minority members of the  
 566.5 legislative committees with jurisdiction over health care policy and finance, by January 15,  
 566.6 2025, a report comparing service delivery and payment system models for delivering services  
 566.7 to MinnesotaCare enrollees eligible under Minnesota Statutes, section 256L.04, subdivisions  
 566.8 1, 7, and 15. The report must compare the current delivery model with at least two alternative  
 566.9 models. The alternative models must include a state-based model in which the state holds  
 566.10 the plan risk as the insurer and may contract with a third-party administrator for claims  
 566.11 processing and plan administration. The alternative models may include but are not limited  
 566.12 to:

566.13 (1) expanding the use of integrated health partnerships under Minnesota Statutes, section  
 566.14 256B.0755;

566.15 (2) delivering care under fee-for-service through a primary care case management system;  
 566.16 and

566.17 (3) continuing to contract with managed care and county-based purchasing plans for  
 566.18 some or all enrollees under modified contracts.

566.19 (d) The report must also include:

566.20 (1) a description of how each model would address:

566.21 (i) racial inequities in the delivery of health care and health care outcomes;

566.22 (ii) geographic inequities in the delivery of health care;

566.23 (iii) incentives for preventive care and other best practices; and

566.24 (iv) reimbursement of providers for high-quality, value-based care at levels sufficient  
 566.25 to sustain or increase enrollee access to care;

566.26 (2) a comparison of the projected cost of each model; and

566.27 (3) an implementation timeline for each model that includes the earliest date by which  
 566.28 each model could be implemented if authorized during the 2025 legislative session.

566.29 **EFFECTIVE DATE.** This section is effective the day following final enactment.

567.1 Sec. 26. **REQUEST FOR FEDERAL APPROVAL.**

567.2 (a) The commissioner of human services must seek all federal waivers, approvals, and  
 567.3 law changes necessary to implement a MinnesotaCare public option and any related changes  
 567.4 to state law, including but not limited to those waivers, approvals, and law changes necessary  
 567.5 to allow the state to:

88.1 (5) draft legislation that includes any additional policy and conforming changes necessary  
 88.2 to implement the MinnesotaCare public option and the implementation plan  
 88.3 recommendations.

88.4 **EFFECTIVE DATE.** This section is effective the day following final enactment.

88.5 Sec. 28. **REQUEST FOR FEDERAL APPROVAL.**

88.6 (a) The commissioner of human services shall seek any federal waivers, approvals, and  
 88.7 law changes necessary to implement the MinnesotaCare public option under Minnesota  
 88.8 Statutes, section 256L.04, subdivision 15, including but not limited to those waivers,  
 88.9 approvals, and law changes necessary to allow the state to:

567.6 (1) continue receiving federal basic health program payments for basic health  
567.7 program-eligible MinnesotaCare enrollees and to receive other federal funding for the  
567.8 MinnesotaCare public option;

567.9 (2) receive federal payments equal to the value of premium tax credits and cost-sharing  
567.10 reductions that MinnesotaCare enrollees with household incomes greater than 200 percent  
567.11 of the federal poverty guidelines would otherwise have received; and

567.12 (3) receive federal payments equal to the value of emergency medical assistance that  
567.13 would otherwise have been paid to the state for covered services provided to eligible  
567.14 enrollees.

567.15 (b) In implementing this section, the commissioner of human services must contract  
567.16 with one or more independent entities to conduct an actuarial analysis of the implementation,  
567.17 administration, and effects of the provisions of a MinnesotaCare public option and any  
567.18 related changes to state law, including but not limited to benefits, costs, impacts on coverage,  
567.19 and affordability to the state and eligible enrollees, impacts on the state's individual market,  
567.20 and compliance with federal law, at a minimum as necessary to obtain any waivers, approvals,  
567.21 and law changes sought under this section.

567.22 (c) In implementing this section, the commissioner of human services must consult with  
567.23 the commissioner of commerce and the Board of Directors of MNsure and may contract  
567.24 for technical assistance.

567.25 **EFFECTIVE DATE.** This section is effective the day following final enactment.

567.26 Sec. 27. **ANALYSIS OF BENEFITS AND COSTS OF A UNIVERSAL HEALTH**  
567.27 **CARE SYSTEM.**

567.28 Subdivision 1. **Definitions.** (a) "Total public and private health care spending" means:

567.29 (1) spending on all medical care including but not limited to dental, vision and hearing,  
567.30 mental health, chemical dependency treatment, prescription drugs, medical equipment and  
567.31 supplies, long-term care, and home care, whether paid through premiums, co-pays and  
568.1 deductibles, other out-of-pocket payments, or other funding from government, employers,  
568.2 or other sources; and

568.3 (2) the costs associated with administering, delivering, and paying for the care. The costs  
568.4 of administering, delivering, and paying for the care includes all expenses by insurers,  
568.5 providers, employers, individuals, and government to select, negotiate, purchase, and  
568.6 administer insurance and care including but not limited to coverage for health care, dental,  
568.7 long-term care, prescription drugs, medical expense portions of workers compensation and

88.10 (1) continue receiving federal basic health program payments for basic health  
88.11 program-eligible MinnesotaCare enrollees and to receive other federal funding for the  
88.12 MinnesotaCare public option;

88.13 (2) receive federal payments equal to the value of premium tax credits and cost-sharing  
88.14 reductions that MinnesotaCare enrollees with household incomes greater than 200 percent  
88.15 of the federal poverty guidelines would otherwise have received; and

88.16 (3) receive federal payments equal to the value of emergency medical assistance that  
88.17 would otherwise have been paid to the state for covered services provided to eligible  
88.18 enrollees.

88.19 (b) In implementing this section, the commissioner of human services shall consult with  
88.20 the commissioner of commerce and the Board of Directors of MNsure and may contract  
88.21 for technical and actuarial assistance.

88.22 **EFFECTIVE DATE.** This section is effective the day following final enactment.

88.23 Sec. 29. **ANALYSIS OF BENEFITS AND COSTS OF UNIVERSAL HEALTH CARE**  
88.24 **SYSTEM REFORM MODELS.**

88.25 Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have  
88.26 the meanings given.

THE FOLLOWING PARAGRAPH WAS MOVED UP FROM UES2995-2,  
ARTICLE 2, SECTION 29, SUBDIVISION 1, PARAGRAPH (F)

89.8 (f) "Total public and private health care spending" means:

89.9 (1) spending on all medical care including but not limited to dental, vision and hearing,  
89.10 mental health, chemical dependency treatment, prescription drugs, medical equipment and  
89.11 supplies, long-term care, and home care, whether paid through premiums, co-pays and  
89.12 deductibles, other out-of-pocket payments, or other funding from government, employers,  
89.13 or other sources; and

89.14 (2) the costs associated with administering, delivering, and paying for the care. The costs  
89.15 of administering, delivering, and paying for the care includes all expenses by insurers,  
89.16 providers, employers, individuals, and the government to select, negotiate, purchase, and  
89.17 administer insurance and care including but not limited to coverage for health care, dental,  
89.18 long-term care, prescription drugs, and the medical expense portions of workers compensation

568.8 automobile insurance, and the cost of administering and paying for all health care products  
568.9 and services that are not covered by insurance.

568.10 (b) "All necessary care" means the full range of services listed in the proposed Minnesota  
568.11 Health Plan legislation, including medical, dental, vision and hearing, mental health, chemical  
568.12 dependency treatment, reproductive and sexual health, prescription drugs, medical equipment  
568.13 and supplies, long-term care, home care, and coordination of care.

568.14 Subd. 2. **Initial assumptions.** (a) When calculating administrative savings under the  
568.15 universal health proposal, the analysts shall recognize that simple, direct payment of medical  
568.16 services avoids the need for provider networks, eliminates prior authorization requirements,  
568.17 and eliminates administrative complexity of other payment schemes along with the need  
568.18 for creating risk adjustment mechanisms, and measuring, tracking, and paying under those  
568.19 risk adjusted or nonrisk adjusted payment schemes by both providers and payors.

568.20 (b) The analysts shall assume that, while gross provider payments may be reduced to  
568.21 reflect reduced administrative costs, net provider income would remain similar to the current  
568.22 system. However, they shall not assume that payment rate negotiations will track current  
568.23 Medicaid, Medicare, or market payment rates or a combination of those rates, because  
568.24 provider compensation, after adjusting for reduced administrative costs, would not be  
568.25 universally raised or lowered but would be negotiated based on market needs, so provider  
568.26 compensation might be raised in an underserved area such as mental health but lowered in  
568.27 other areas.

568.28 **EFFECTIVE DATE.** This section is effective the day following final enactment.

568.29 Sec. 28. **BENEFIT AND COST ANALYSIS OF A UNIVERSAL HEALTH REFORM**  
568.30 **PROPOSAL.**

568.31 Subdivision 1. **Contract for analysis of proposal.** The commissioner of health shall  
568.32 contract with one or more independent entities to conduct an analysis of the benefits and  
568.33 costs of a legislative proposal for a universal health care financing system and a similar  
569.1 analysis of the current health care financing system to assist the state in comparing the

89.19 and automobile insurance, and the cost of administering and paying for all health care  
89.20 products and services that are not covered by insurance.

88.27 (b) "All necessary care" means the full range of services listed in the proposed Minnesota  
88.28 Health Plan legislation, including medical, dental, vision and hearing, mental health, chemical  
88.29 dependency treatment, reproductive and sexual health, prescription drugs, medical equipment  
88.30 and supplies, long-term care, home care, and coordination of care.

89.1 (c) "Direct payment system" means the health care delivery system authorized by  
89.2 Minnesota Statutes, section 256.9631.

89.3 (d) "MinnesotaCare public option" means the MinnesotaCare expansion to cover  
89.4 individuals eligible under Minnesota Statutes, section 256L.04, subdivision 15.

89.5 (e) "Other reform models" means alternative models of health care reform, which may  
89.6 include changes to health system administration, payments, or benefits, and may be  
89.7 comprehensive or specific to selected market segments or populations.

UES2995-2, ARTICLE 2, SECTION 29, SUBDIVISION 1, PARAGRAPH (F)  
WAS MOVED UP TO MATCH S2995-3, ARTICLE 16, SECTION 27,  
SUBDIVISION 1, PARAGRAPH (A)

89.21 Subd. 2. **Initial assumptions.** (a) When calculating administrative savings under the  
89.22 universal health proposal, the analysts shall recognize that simple, direct payment of medical  
89.23 services avoids the need for provider networks, eliminates prior authorization requirements,  
89.24 and eliminates administrative complexity of other payment schemes along with the need  
89.25 for creating risk adjustment mechanisms, and measuring, tracking, and paying under those  
89.26 risk adjusted or nonrisk adjusted payment schemes by both providers and payors.

89.27 (b) The analysts shall assume that, under the universal health proposal, while gross  
89.28 provider payments may be reduced to reflect reduced administrative costs, net provider  
89.29 income would remain similar to the current system. However, they shall not assume that  
89.30 payment rate negotiations will track current Medicaid, Medicare, or market payment rates  
89.31 or a combination of those rates, because provider compensation, after adjusting for reduced  
89.32 administrative costs, would not be universally raised or lowered but would be negotiated  
89.33 based on market needs, so provider compensation might be raised in an underserved area  
89.34 such as mental health but lowered in other areas.

90.1 Subd. 3. **Contract for analysis of proposals; analytic tool.** (a) The commissioner of  
90.2 health shall contract with one or more independent entities to:

90.3 (1) conduct an analysis of the benefits and costs of a legislative proposal for a universal  
90.4 health care financing system, based on the legislative proposal known as the Minnesota



569.2 proposal to the current system. The contract must strive to produce estimates for all elements  
 569.3 in subdivision 3.

569.4 Subd. 2. **Proposal.** The commissioner of health, with input from the commissioners of  
 569.5 human services and commerce, shall submit to the contractor for analysis the legislative  
 569.6 proposal known as the Minnesota Health Plan, proposed in 2023 Senate File No. 2740;  
 569.7 House File No. 2798, if enacted, that would offer a universal health care plan designed to  
 569.8 meet a set of principles, including:

569.9 (1) ensure all Minnesotans are covered;

569.10 (2) cover all necessary care; and

569.11 (3) allow patients to choose their doctors, hospitals, and other providers.

569.12 Subd. 3. **Proposal analysis.** (a) The analysis must measure the performance of both the  
 569.13 proposed Minnesota Health Plan and the current public and private health care financing  
 569.14 system over a ten-year period to contrast the impact on:

569.15 (1) coverage: the number of people who are uninsured versus the number of people who  
 569.16 are insured;

569.17 (2) benefit completeness: adequacy of coverage measured by the completeness of the  
 569.18 coverage and the number of people lacking coverage for key necessary care elements such  
 569.19 as dental, long-term care, medical equipment or supplies, vision and hearing, or other health  
 569.20 services that are not covered, if any. The analysis must take into account the vast variety of  
 569.21 benefit designs in the commercial market and report the extent of coverage in each area;

569.22 (3) underinsurance: whether people with coverage can afford the care they need or  
 569.23 whether cost prevents them from accessing care. This includes affordability in terms of  
 569.24 premiums, deductibles, and out-of-pocket expenses;

569.25 (4) system capacity: the timeliness and appropriateness of the care received and whether  
 569.26 people turn to inappropriate care such as emergency rooms because of a lack of proper care  
 569.27 in accordance with clinical guidelines; and

569.28 (5) health care spending: total public and private health care spending in Minnesota  
 569.29 under the current system versus under the Minnesota Health Plan legislative proposal,

90.5 Health Plan (Regular Session 2023, Senate File No. 2740/House File No. 2798) and a similar  
 90.6 analysis of the current health care financing system to assist the state in comparing the  
 90.7 proposal to the current system; and

90.8 (2) conduct an analysis of the MinnesotaCare public option, the direct payment system,  
 90.9 and other reform models, and a similar analysis of the current health care financing system  
 90.10 to assist the state in comparing the models to the current system.

90.11 (b) In conducting these analyses, the contractor or contractors shall develop and use an  
 90.12 analytic tool that meets the requirements in subdivision 4, and shall also make this analytic  
 90.13 tool available for use by the commissioner.

90.14 (c) The commissioner shall issue a request for information. Based on responses to the  
 90.15 request for information, the commissioner shall issue a request for proposals that specifies  
 90.16 requirements for the design, analysis, and deliverables, and shall select one or more  
 90.17 contractors based on responses to the request for proposals. The commissioner shall consult  
 90.18 with the chief authors of this act in implementing this paragraph.

90.19 Subd. 4. **Requirements for analytic tool.** (a) The analytic tool must be able to assess  
 90.20 and model the impact of the Minnesota Health Plan, the direct payment system, the  
 90.21 MinnesotaCare public option, and other reform models on the following:

90.22 (1) coverage: the number of people who are uninsured versus the number of people who  
 90.23 are insured;

90.24 (2) benefit completeness: adequacy of coverage measured by the completeness of the  
 90.25 coverage and the number of people lacking coverage for key necessary care elements such  
 90.26 as dental, long-term care, medical equipment or supplies, vision and hearing, or other health  
 90.27 services that are not covered, if any. The analysis must take into account the vast variety of  
 90.28 benefit designs in the commercial market and report the extent of coverage in each area;

90.29 (3) underinsurance: whether people with coverage can afford the care they need or  
 90.30 whether cost prevents them from accessing care. This includes affordability in terms of  
 90.31 premiums, deductibles, and out-of-pocket expenses;

91.1 (4) system capacity: the timeliness and appropriateness of the care received and whether  
 91.2 people turn to inappropriate care such as emergency rooms because of a lack of proper care  
 91.3 in accordance with clinical guidelines; and

91.4 (5) health care spending: total public and private health care spending in Minnesota,  
 91.5 including all spending by individuals, businesses, and government. Where relevant, the

569.30 including all spending by individuals, businesses, and government. Where relevant, the  
569.31 analysis shall be broken out by key necessary care areas, such as medical, dental, and mental  
569.32 health. The analysis of total health care spending shall examine whether there are savings  
569.33 or additional costs under the legislative proposal compared to the existing system due to:

570.1 (i) changes in cost of insurance, billing, underwriting, marketing, evaluation, and other  
570.2 administrative functions for all entities involved in the health care system, including savings  
570.3 from global budgeting for hospitals and institutional care instead of billing for individual  
570.4 services provided;

570.5 (ii) changed prices on medical services and products, including pharmaceuticals, due to  
570.6 price negotiations under the proposal;

570.7 (iii) impact on utilization, health outcomes, and workplace absenteeism due to prevention,  
570.8 early intervention, and health-promoting activities;

570.9 (iv) shortages or excess capacity of medical facilities, equipment, and personnel, including  
570.10 caregivers and staff, under either the current system or the proposal, including capacity of  
570.11 clinics, hospitals, and other appropriate care sites versus inappropriate emergency room  
570.12 usage. The analysis shall break down capacity by geographic differences such as rural versus  
570.13 metro, and disparate access by population group;

570.14 (v) the impact on state, local, and federal government non-health-care expenditures.  
570.15 This may include areas such as reduced crime and out-of-home placement costs due to  
570.16 mental health or chemical dependency coverage. Additional definition may further develop  
570.17 hypotheses for other impacts that warrant analysis;

570.18 (vi) job losses or gains within the health care system; specifically, in health care delivery,  
570.19 health billing, and insurance administration;

570.20 (vii) job losses or gains elsewhere in the economy under the proposal due to  
570.21 implementation of the resulting reduction of insurance and administrative burdens on  
570.22 businesses; and

570.23 (viii) impact on disparities in health care access and outcomes.

570.24 (b) The contractor or contractors shall propose an iterative process for designing and  
570.25 conducting the analysis. Steps shall be reviewed with and approved by the commissioner  
570.26 of health and lead house and senate authors of the legislative proposal, and shall include  
570.27 but not be limited to:

570.28 (1) clarification of the specifics of the proposal. The analysis shall assume that the  
570.29 provisions in the proposal are not preempted by federal law or that the federal government  
570.30 gives a waiver to the preemptions;

570.31 (2) additional data elements needed to accomplish goals of the analysis;

91.6 analysis shall be broken out by key necessary care areas, such as medical, dental, and mental  
91.7 health. The analysis of total health care spending shall examine whether there are savings  
91.8 or additional costs under the legislative proposal compared to the existing system due to:

91.9 (i) changes in cost of insurance, billing, underwriting, marketing, evaluation, and other  
91.10 administrative functions for all entities involved in the health care system, including savings  
91.11 from global budgeting for hospitals and institutional care instead of billing for individual  
91.12 services provided;

91.13 (ii) changed prices on medical services and products, including pharmaceuticals, due to  
91.14 price negotiations under the proposal;

91.15 (iii) impact on utilization, health outcomes, and workplace absenteeism due to prevention,  
91.16 early intervention, and health-promoting activities;

91.17 (iv) shortages or excess capacity of medical facilities, equipment, and personnel, including  
91.18 caregivers and staff, under either the current system or the proposal, including capacity of  
91.19 clinics, hospitals, and other appropriate care sites versus inappropriate emergency room  
91.20 usage. The analysis shall break down capacity by geographic differences such as rural versus  
91.21 metro, and disparate access by population group;

91.22 (v) the impact on state, local, and federal government non-health-care expenditures.  
91.23 This may include areas such as reduced crime and out-of-home placement costs due to  
91.24 mental health or chemical dependency coverage. Additional definition may further develop  
91.25 hypotheses for other impacts that warrant analysis;

91.26 (vi) job losses or gains within the health care system; specifically, in health care delivery,  
91.27 health billing, and insurance administration;

91.28 (vii) job losses or gains elsewhere in the economy under the proposal due to  
91.29 implementation of the resulting reduction of insurance and administrative burdens on  
91.30 businesses; and

91.31 (viii) impacts on disparities in health care access and outcomes.

571.1 (3) assumptions analysts are using in their analysis and the quality of the evidence behind  
571.2 those assumptions;

571.3 (4) timing of each stage of the project with agreed upon decision points;

571.4 (5) approaches to address any services currently provided in the existing health care  
571.5 system that may not be provided for within the Minnesota Health Plan as proposed; and

571.6 (6) optional scenarios provided by contractor or contractors with minor alterations in  
571.7 the proposed plan related to services covered or cost-sharing if those scenarios might be  
571.8 helpful to the legislature.

571.9 (c) The commissioner shall issue a final report by January 15, 2026, and may provide  
571.10 interim reports and status updates to the governor and the chairs and ranking minority  
571.11 members of the legislative committees with jurisdiction over health and human services  
571.12 policy and finance aligned with the iterative process defined above.

571.13 (d) The contractor may offer a modeling tool as deliverable with a line-item cost provided.

571.14 **EFFECTIVE DATE.** This section is effective the day following final enactment.

91.32 (b) The analytic tool must:

92.1 (1) have the capacity to conduct interactive microsimulations;

92.2 (2) allow comparisons between the Minnesota Health Plan, the direct payment system,  
92.3 the MinnesotaCare public option, the current delivery system, and other reform models, on  
92.4 the relative impact of these delivery approaches on the variables described in paragraph (a);  
92.5 and

92.6 (3) allow comparisons based on differing assumptions about the characteristics and  
92.7 operation of the delivery approaches.

92.8 Subd. 5. **Analyses by the commissioner.** The commissioner, in cooperation with the  
92.9 commissioners of human services and commerce and the legislature, may use the analytic  
92.10 tool to assist in the development, design, and analysis of reform models under consideration  
92.11 by the legislature and state agencies, and to supplement the analyses of the Minnesota Health  
92.12 Plan, the MinnesotaCare public option, and the direct payment system conducted by the  
92.13 contractor or contractors under this section.

92.14 Subd. 6. **Report and delivery of analytic tool.** (a) The contractor or contractors, by  
92.15 January 15, 2026, shall report findings and recommendations to the commissioner, and to  
92.16 the chairs and ranking minority members of the legislative committees with jurisdiction  
92.17 over health care and commerce, on the design and implementation of the Minnesota Health  
92.18 Plan, the MinnesotaCare public option, and the direct payment system. The findings and  
92.19 recommendations must address the feasibility and affordability of the proposals, and the  
92.20 projected impact of the proposals on the variables listed in subdivision 4.

92.21 (b) The contractor or contractors shall make the analytic tool available to the  
92.22 commissioner by January 15, 2026.

571.15 Sec. 29. **APPOINTMENTS AND INITIAL MEETING OF THE HEALTH CARE**  
571.16 **AFFORDABILITY BOARD.**

571.17 Appointing authorities must make first appointments to the Health Care Affordability  
571.18 Board under Minnesota Statutes, section 62J.87, by October 1, 2023. The governor must  
571.19 designate one member to serve as an acting chair until the council selects a chair at its first  
571.20 meeting. The acting chair must convene the first meeting by January 1, 2024.

571.21 Sec. 30. **TERMS OF INITIAL APPOINTEES OF THE HEALTH CARE**  
571.22 **AFFORDABILITY ADVISORY COUNCIL.**

571.23 Notwithstanding Minnesota Statutes, section 62J.88, subdivision 3, the initial appointed  
571.24 members of the Health Care Affordability Advisory Council under Minnesota Statutes,  
571.25 section 62J.88, shall serve staggered terms of two, three, and four years determined by lot  
571.26 by the secretary of state.

571.27 Sec. 31. **REPEALER.**

571.28 Minnesota Statutes 2022, section 256B.0631, subdivisions 1, 2, and 3, are repealed.

571.29 **EFFECTIVE DATE.** This section is effective July 1, 2025.

572.1 Sec. 32. **CONTINGENT EFFECTIVE DATE.**

572.2 Sections 16, 18, and 19, and the specified portion of section 20, are effective January 1,  
572.3 2027, or upon federal approval, whichever is later, but only if the commissioner of human  
572.4 services certifies to the legislature the following:

572.5 (1) that implementation of those sections will not result in substantial reduction in federal  
572.6 basic health program funding for MinnesotaCare enrollees with incomes not exceeding 200  
572.7 percent of the federal poverty guidelines;

572.8 (2) premiums necessary to operationalize the program are deemed affordable in  
572.9 accordance with applicable federal law;

572.10 (3) the actuarial value of benefit does not fall below 94 percent and the benefit set is  
572.11 equal to or greater than that historically available in MinnesotaCare;

572.12 (4) the 1332 waiver was approved consistent, or without substantial deviation, from the  
572.13 implementation plan;

572.14 (5) the commissioner of commerce certifies that the public option would expand plan  
572.15 options available for individuals purchasing coverage;

572.16 (6) the state receives a substantially similar pass-through funding amount from the federal  
572.17 government that would have otherwise gone to enrollees' advanced premium tax credits;

572.18 (7) individuals currently served by the MinnesotaCare program are not disproportionately  
572.19 or substantively negatively impacted in order to make the public option affordable or  
572.20 implementable; and

572.21 (8) individuals currently served by the Medical Assistance program are not  
572.22 disproportionately or substantively negatively impacted in order to make the public option  
572.23 affordable or implementable.

572.24 The commissioner of human services shall notify the revisor of statutes when federal approval  
572.25 is obtained.